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Vermont Blueprint for Health

2014 Annual Report
January 15, 2015

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FOREWORD

The Vermont Blueprint for Health (Blueprint) is described in statute as "*a program for integrating a system of health care for patients, improving the health of the overall population, and improving control over health care costs by promoting health maintenance, prevention, and care coordination and management.*[1]"

The Blueprint works with practices, hospitals, health centers, and other stakeholders to implement a statewide health service model in Vermont. The model includes advanced primary care in the form of patient centered medical homes (PCMHs), multi-disciplinary support services in the form of community health teams (CHTs), a network of self-management support programs, comparative reporting from statewide data systems, and activities focused on continuous improvement (Learning Health System). The program aims to assure that all citizens have access to high quality primary care and preventive health services, and to establish a foundation for a high value health system in Vermont.

This annual report provides updates on the growth of the program, evaluation results on cost containment and health improvement, and progress in building an integrated system of health care. As many readers are familiar with the Blueprint programs, the new material on expansion and work towards integrating systems of care precedes the general description of the Blueprint payment reforms, and services.

This year, the Blueprint, in collaboration with the Agency of Administration and the Green Mountain Care Board, published two additional reports. The first, in accordance with Act 144, Section 17, outlined recommendations on:

"whether and to what extent to increase payments to health care providers and community health teams for their participation in the Blueprint for Health and whether to expand the Blueprint to include additional services or chronic conditions such as obesity, mental conditions, and oral health."

The resulting *Blueprint for Health Report: Medical Homes, Teams and Community Health Systems* was published October, 2014. This document includes key material from that report and includes updates reflecting further progress since October.

[1] 18 VSA Chapter 13.

The second, in accordance with Act 144 Section 16, tasked the Director of the Vermont Blueprint for Health and the Chair of the Green Mountain Care Board Act to report on:[2]

"*the relationship between adverse childhood experiences (ACEs) and population health*" to include recommendations on "*whether, how, and at what expense ACE-informed medical practice should be integrated into Blueprint practices and community health teams*". In addition, to " . . .*develop a methodology by which the Blueprint will evaluate emerging health care delivery quality initiatives to determine whether, how, and to what extent they should be integrated into the Blueprint for Health.*"

The ACEs report will be submitted to the General Assembly of the Vermont Legislature by January 15, 2015 as a separate document.

[2] Act 144 Section 16

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1. EXECUTIVE SUMMARY

2014 was a dynamic year for healthcare reform activities in Vermont. The Provider Networks that make up the One Care, Community Health Accountable Care and Health First Accountable Care Organizations (ACOs) completed network development agreements and reported under the first round of Shared Savings Plans. The Vermont Health Care Innovation Project (VHCIP), funded by the State Innovation Model (SIM) grant, developed a common set of core measures for the Medicaid and Commercial Insurance shared savings programs. VHCIP also made significant investments in the three Provider Networks (ACOs) to build capacity for quality improvement, data analytics and care redesign. VHCIP awarded $4,903,145 to fourteen provider entities for innovation projects and worked to develop a care coordination collaborative. With the support from VHCIP grants, the Provider Networks and the Blueprint for Health worked together to plan a unified approach to local health system development and reform.

Medicare extended Vermont's Multi-payer Advanced Primary Care Practice demonstration program (MAPCP), allowing continued participation in the Blueprint payment and service reforms, including for the Support and Services at Home (SASH) program.

In this environment, the Blueprint continued to develop a system of integrated health care services and build on the program's foundation of delivery system and financial reforms. Specifically:

- Primary care practices gained formal recognition as Patient Centered Medical Homes for the first time and others re-scored against the National Committee for Quality Assurance (NCQA) quality standards.
- Community Health Team (CHT) operations matured and the CHTs worked to coordinate care across medical and community partnering organizations
- Local multi-stakeholder workgroups, staffed by the Blueprint, focused on bridging health and human services to maximize available resources, improve outcomes, and drive clinical quality improvement.
- A new unified reporting capability for clinical, cost and utilization measures produced timely reports across all payers at the practice, Health Services Area, and State levels. These reports form the basis for aligning local and statewide quality improvement efforts.

Based on feedback that the payments for NCQA recognition and for CHTs were no longer adequate, the Blueprint initiated systematic discussions with local physicians and health systems statewide to develop new approaches to payment. The October 2014 report reflects continued evolution of targeted payment reforms and includes, for the first time, proposals for how payment reforms can be evolved to incent improved outcomes.

Blueprint leadership has worked intensively with all three Provider Networks participating in ACO Shared Savings Plans and the VHCIP workgroups to align work and leverage existing resources at the state and local levels. Out of this collaboration, three current priorities have emerged.

1.a. Priority 1: Unified Community Health Systems

In each Health Service Area (HSA), providers, Blueprint project managers, and Provider Network leadership have merged, or are planning to merge, previously disparate workgroups and developing a shared governance structure. This governance structure includes medical and non-medical providers and is designed to provide balanced local leadership for quality improvement and coordination initiatives. The unified community health system design will focus on improving the results of core ACO quality measures, support the introduction and extension of new service models, and provide guidance for medical home and CHT operations.

The unified approach reduces the number of overlapping initiatives, establishes a data-guided community health system collaborative, and will result in more effective health and human services. Existing Blueprint and VHCIP resources are being deployed to support these collaboratives, including local project managers, practice facilitators, self-management programs, shared evaluation and comparative reporting, and shared learning forums.

1.b. Priority 2: Unified Performance Reporting & Data Utility

Providers, the Blueprint team, and Provider Network leadership are piloting the co-production of performance dashboards that include results for VHCIP's core ACO measures, as well as other analytics important to supporting care delivery transformation. These dashboards present population-level results and directly support the work of unified community collaboratives.

These dashboards will augment the suite of comparative profiles currently produced for primary care practices, Health Services Areas, and organizations, providing a focused set of results important to all entities participating in ACO activity. Where possible, this approach can be generalized to include sharing data sets, collaborating on analytic activity, and planning for an advanced data infrastructure that will support the range of data management, reporting and utilization needs of Vermont's health system.

1.c. Priority 3: Payment Modifications

Participating providers have not seen an increase in payments, despite the improved outcomes and decreased costs, since the Blueprint for Health launched in 2008. Modifications to current Blueprint payments can help optimize the effectiveness of the evolving community health system of patient-centered medical homes (PCMHs), CHTs, and Unified Community Collaboratives.

The Blueprint for Health has been a foundation of our reform efforts, but additional investment is necessary to support the continued transformation of health care delivery in the future. The Governor's budget proposal, submitted to the general assembly on January 15, 2015, invests over $4.5 million in state fiscal year 2016, more than doubling Medicaid's Blueprint provider contributions. In fiscal year 2016, the Governor's Medicaid budget proposes increases for the community health team payments by $540,000, increases Medicaid's share of CHT payments by $470,000 to allow rebalancing among payers, and adds $3.5 million to medical home payments and new payment innovations. When annualized, this would provide over $8 million in new funding to support provider payments through the Blueprint, beginning January 1, 2016.

New payment modification options include:

1. Increase community health team payments to provide Vermonters with greater access to multi-disciplinary preventive services and the teams with adequate administrative support

2. Increase medical home payments to maintain practice participation and incent level 3 National Committee for Quality Assurance (NCQA)-Patient-centered Medical Home (PCMH) recognition

3. Add an outcomes-based payment to directly incent the goals of the unified community collaboratives to improve on core ACO quality measures and reduce avoidable utilization of health care services.

If approved by the legislature, the funds proposed in the Governor's budget will allow for Medicaid to lead the way and promote these changes in payments. In addition, the Blueprint will be working to ensure that all payers similarly increase their contributions, in order to ensure that the Blueprint for Health continues as a multi-payer initiative.

1.c.1. Progress on the Priorities

Since the October report, the three Provider Networks (One Care, CHAC, and Health First) and the Blueprint have developed a proposal for Unified Community Collaboratives. The Collaboratives will be led by a local leadership team that includes medical and non-medical providers, to focus on data-driven quality and coordination initiatives. A detailed operations plan is in development and Blueprint staff and resources have been tasked to support local unified collaborative health systems development activities.

In addition, we have produced comparative performance profiles at the practice, organization, network, and health service area levels. For the first time, the 2014 Hospital Services Area (HSA) profiles include Medicare healthcare claims data in addition to Medicaid and commercial insurer claims. In addition, the 2014 HSA profiles include results for many of the VHCIP core ACO measures, some of which are generated by a "first time" linkage of clinical data from the statewide clinical registry with claims data from the all payer claims database. These profiles are

being used as the basis for quality improvement initiatives in each HSA. Blueprint HSA Profiles can be found at http://hcr.vermont.gov/HSA.

Based on extensive input from providers, insurers, health systems, and other stakeholders, and in alliance with the Green Mountain Care Board (GMCB), the Blueprint began vetting new payment recommendations with a goal for implementation in 2015 and 2016.

In short, 2014 marked a year for the Blueprint to form new partnerships, roll out meaningful performance reporting, and support the next wave of health care delivery reforms.

1.d. Current Operations

As of December 2014 there are 124 primary care practices operating in Vermont as patient centered medical homes (PCMHs) supported by multi-disciplinary community health teams (CHTs). In this program, each practice is scored against the National Committee for Quality Assurance (NCQA) PCMH recognition program standards for high quality patient centered care.

CHTs provide medical home patients with more direct and unhindered access to diverse staff such as nurse care coordinators, social workers, counselors, dieticians, health educators, and others.

PCMHs and CHT staff aim to strengthen network interactions with a larger array of medical and non-medical providers in their community, and to help people link more seamlessly with the services they need. The implementation and expansion of the model has been supported with a locally organized transformation infrastructure including Project Managers, CHT leaders, Practice Facilitators, multi-stakeholder workgroups, and shared learning forums.

Key design principles of the model include: locally-based leadership and organization; consistent statewide quality standards (NCQA PCMH standards) and measurement of performance against those standards; close coordination between primary care, CHT staff, and community based services; and an emphasis on prevention, improved control of established health problems and promotion of healthier lifestyles.

The Blueprint works with a wide range of stakeholders to help organize and extend additional services directed at important needs. One example is the Support and Services at Home Program (SASH). The SASH teams, based at publically subsidized housing sites, include a coordinator and a Wellness nurse for each panel of 100 people. SASH teams focus on assisting high risk Medicare beneficiaries to live more satisfying lifestyles and age more safely in their homes. Another service model is the Hub & Spoke program for patients with opiate addiction and co-occurring mental health problems. This program adds a licensed counselor and nurse coordinator to the CHT (extenders) for Medicaid beneficiaries who are treated in the practice setting (spokes), and increases capacity at five specialty centers (Hubs) for patients with more

complex needs. A third example is the network of self-management programs being offered in all areas of the state including: Healthier Living Workshops for Chronic Disease; Healthier Living Workshops for Diabetes; Healthier Living Workshops for Chronic Pain; and the Diabetes Prevention Program. All components of the program are operating in each Health Service Area in Vermont. A state level summary of key program participants is provided (Table 1).

Table 1. Statewide Program Participants

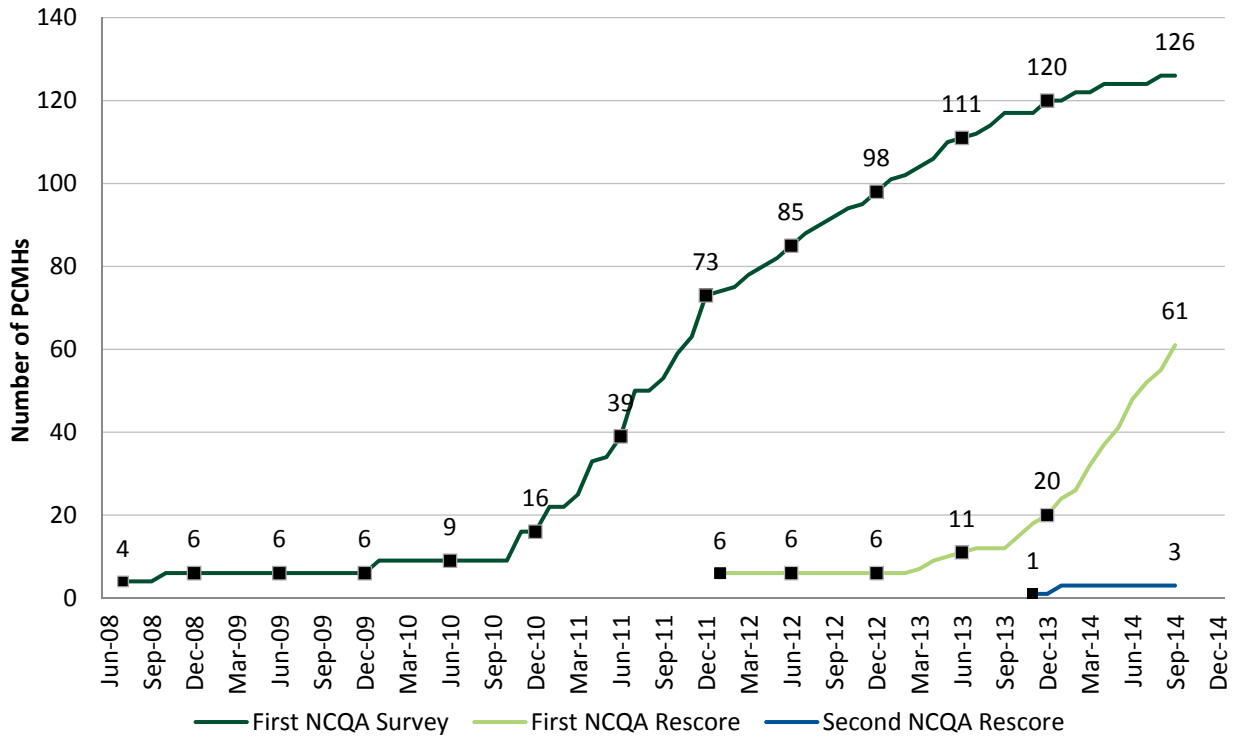
Key Components	December 2014
PCMHs (active PCMHs)	124
PCPs (unique providers)	682
Patients (attribution 12/2013[3])	347,489
Patients (practice report[4])	515,619
CHT Staff (core)	218 staff (135 FTEs)
SASH Staff (extenders)	65 FTEs (52 panels)
Spoke Staff (extenders)	58 staff (39 FTEs)

In each area of the state, participating PCMHs and CHTs have organized their operations to meet the NCQA medical home standards. This process is supported by Practice Facilitators, planning and learning forums, and by the network of self-management programs that help practices meet a particularly challenging section of the standards (Support Self Care Process). A team based at the University of Vermont, in the Vermont Child Health Improvement Program, scores each practice to assure a consistent and independent assessment of healthcare quality. This approach has led to successful recognition of 126 practices, successful re-scoring of 61 practices and a statewide base of primary care tested against difficult national standards (Figure 1).

[3] This is a count of the unique Vermont residents who received the preponderance of their primary care in a medical home in Vermont during the previous 24 months. The count is derived using an attribution algorithm applied to claims data in Vermont's all payer claims data base.

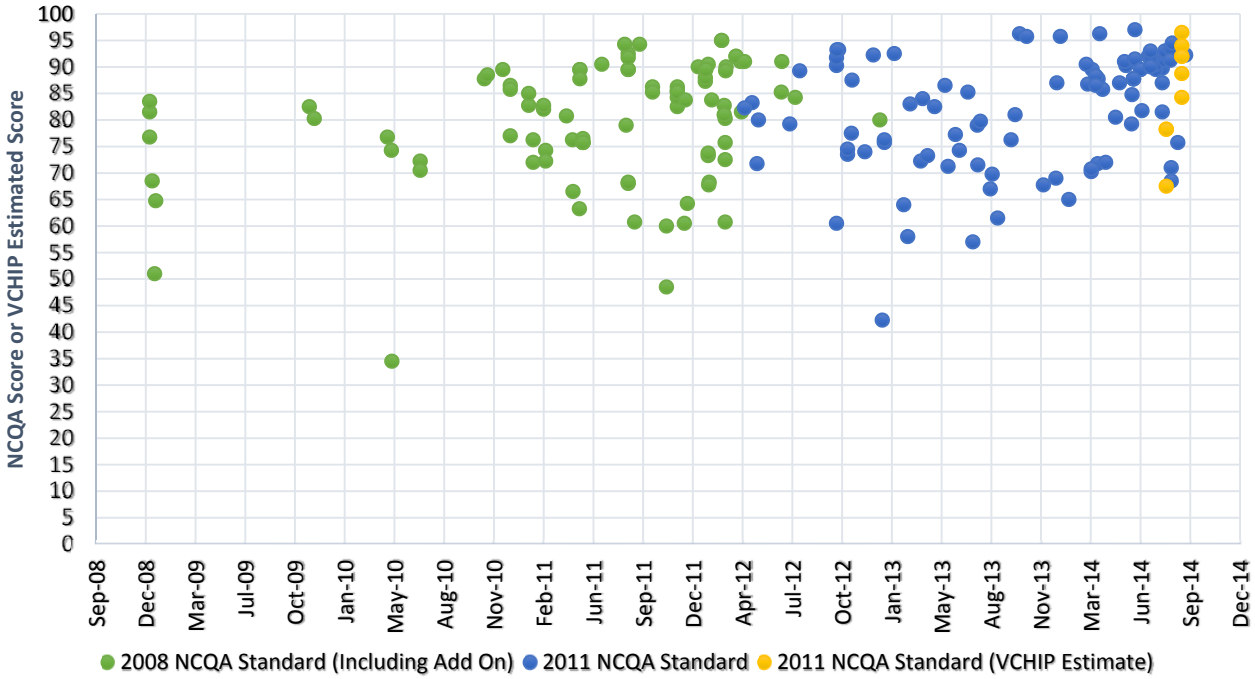
[4] This is the total patient count reported by all medical home practices. It is not a count of unique individuals, and includes patients who go to more than one medical home practice in Vermont, Vermont residents who went to a Vermont medical home practice but receive the preponderance of their primary care in practices outside of Vermont, and non-Vermont residents who received care in medical home practices in Vermont.

Figure 1.Scoring of Patient-Centered Medical Homes in Vermont



The NCQA medical home standards emphasize practices and policies that are considered important ingredients for high quality patient care, and a high value health system. They are based on peer reviewed evidence supplemented by expert opinion, and are updated regularly by NCQA through a highly structured multi-stakeholder process. With each update the standards grow more rigorous, promoting ongoing improvement. Despite the increasing rigor of the standards, medical home scores in Vermont have been maintained and in many cases improved with re-scoring (Figure 2). This is testimony to the dedication, commitment, and hard work on the part of Vermont's primary care providers, and the effectiveness of the supports offered by the Blueprint program.

Figure 2. Practice Scores Over Time with Evolution of the NCQA Medical Home Standards



A substantial investment of clinician and staff time is required for a primary care practice to organize workflow, qualify for recognition, and to truly deliver care in accordance with these standards. While the effort may improve quality, it can interfere with the emphasis on high volume productivity that is required in a fee for service world, and may even compromise revenue to the practice. Clinicians and practice administrators consistently point out that the current medical home payments do not adequately support the time and work effort that is required to produce the documentation, complete the scoring process, and provide clinical services in accordance with these demanding yet important standards. The medical home payments are considered insufficient by many providers to offset the time and effort that it takes to truly operate a patient centered medical home, or the pressures of a fee for service payment system that primarily incentivizes doing more units of billable services.

2. PROGRAM OUTCOMES

2.a. Study Overview

This section discusses the impact of the program on expenditures and patterns of healthcare. The outcomes presented reflect the hard work of dedicated providers across the state and the impact that targeted population-based payments can have. The reforms involved in the program are complex, including substantial reorganization at the practice level, administration and function of Community Health Teams (CHTs), and enhancement of broader service networks in each community.

This report builds on the evaluation study presented in the previous year's annual report by including information through calendar year 2013 and providing a comparison over time of Blueprint practices to primary care as usual. The trends shown in the data indicate that the Blueprint reforms reduce utilization and cost over time. These impacts provide an important context for the recommended options for payment modifications.

Outcomes are presented for *participant* and *comparison* groups with results broken out for commercially insured and Medicaid beneficiaries. For each year, the *participant* population includes Vermont residents who received the majority of their primary care in one of the 123 practices that became a medical home by December 2013. Only a small number of these practices were medical homes in 2008 with an increasing number becoming medical homes as the program expanded, particularly from 2011 through 2013 (Table 2). The results for the *participant* population reflect a changing complex environment as more practices join the program, teams expand, and operations mature.

The *comparison* population includes Vermont residents, in each year, who received the majority of their primary care in a practice that was not a medical home by December 2013. These practices were not involved in the transformation process or supported by CHTs.

The number of people included in the *participant* and *comparison* populations is shown for each year (Table 2). It is important to note that the two groups are similar in terms of demographics and clinical characteristics, and that results are adjusted for differences in age, gender, maternity, prevalence of common chronic diseases, and clinical risk group scoring. Data for this evaluation comes from Vermont's *"all payer claims"* database with analyses conducted by Onpoint Health Data (Onpoint).

Table 2. Study Groups Included in the Blueprint Evaluation

	Participant Practices Included in Evaluation		Commercial (Ages 18-64 Years)		Medicaid (Ages 18-64 Years)	
	Year of entry into the program		Participant	Comparison	Participant	Comparison
2008	6	For each year of the evaluation, the participant population includes all people who received care in practices that would become medical homes by 2013*	118,132	91,106	23,965	15,344
2009	6		136,445	89,452	30,362	15,851
2010	17		145,207	77,980	36,014	14,792
2011	76		156,695	68,281	40,245	12,980
2012	100		162,211	60,045	45,036	11,771
2013	123		160,350	59,402	44,385	12,247

**Shows how results change for the complete group of practices and their population as a complex transformation takes place, avoiding potential bias of progressively increasing the contribution of more advanced practices*

2.a.1. Impact on Health Care Expenditures

In 2008, when the initial Blueprint pilot programs were set up in two communities, total healthcare expenditures per capita were similar for the participant and comparison populations. As the program expanded, year-to-year growth in healthcare expenditures was lower for Blueprint participants, particularly from 2011 forward as more of the 123 practices underwent preparation, scoring, and began working with community health teams (Figures 3 and 4).

Figure 3. Total Expenditures Per Capita - Commercially Insured Ages 18-64

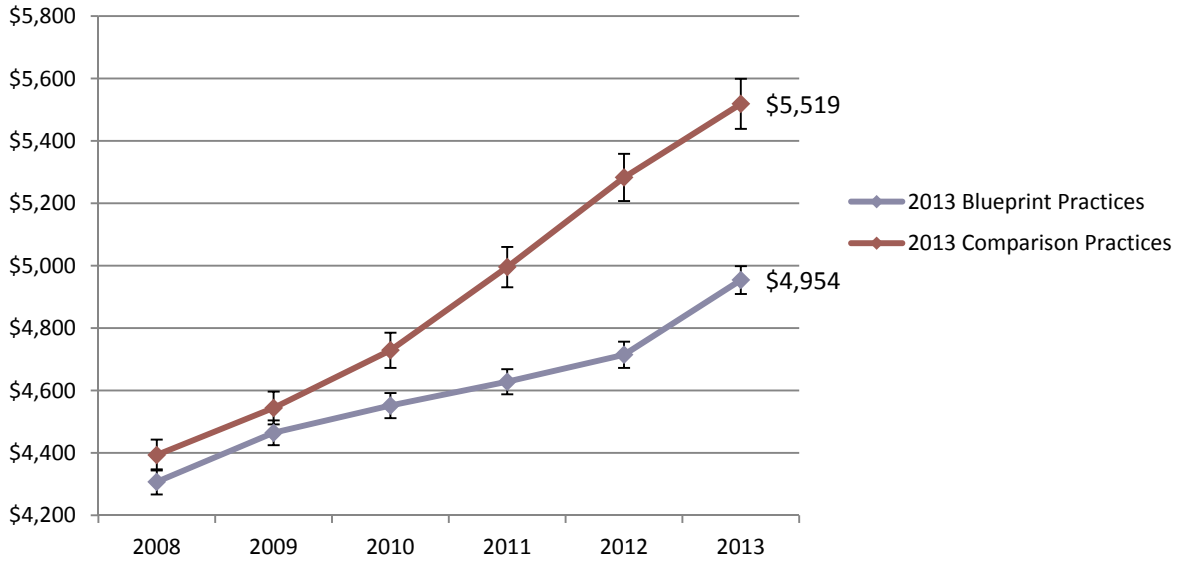
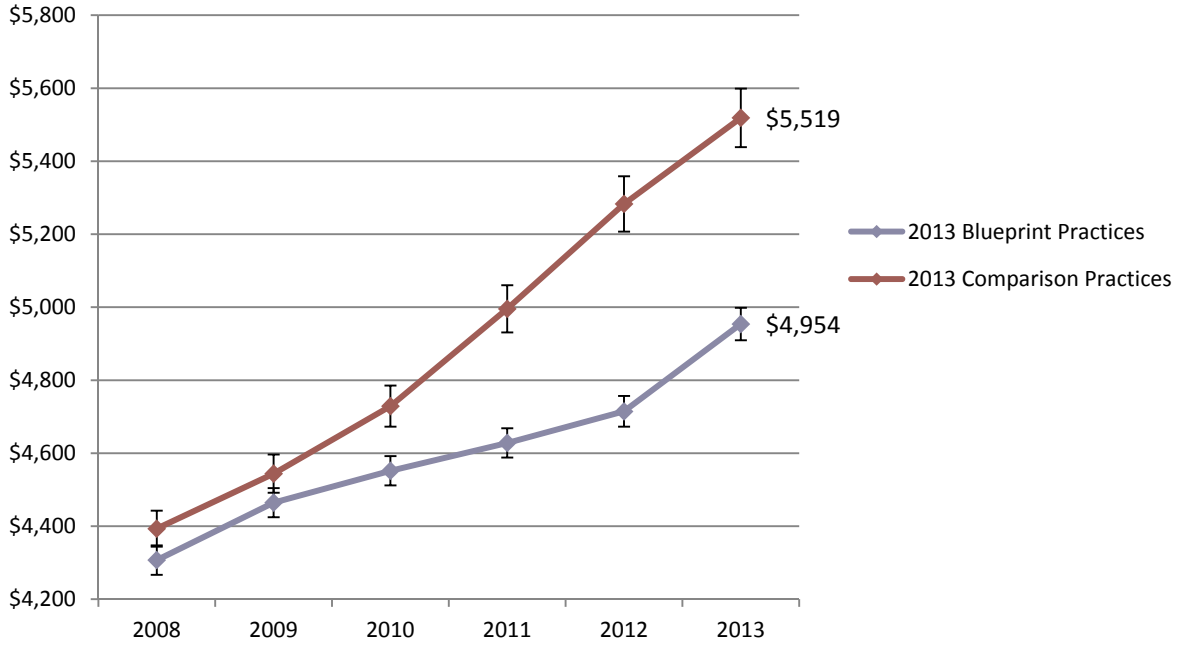


Figure 4. Total Expenditures Per Capita - Medicaid Ages 18-64 (excludes SMS[5])

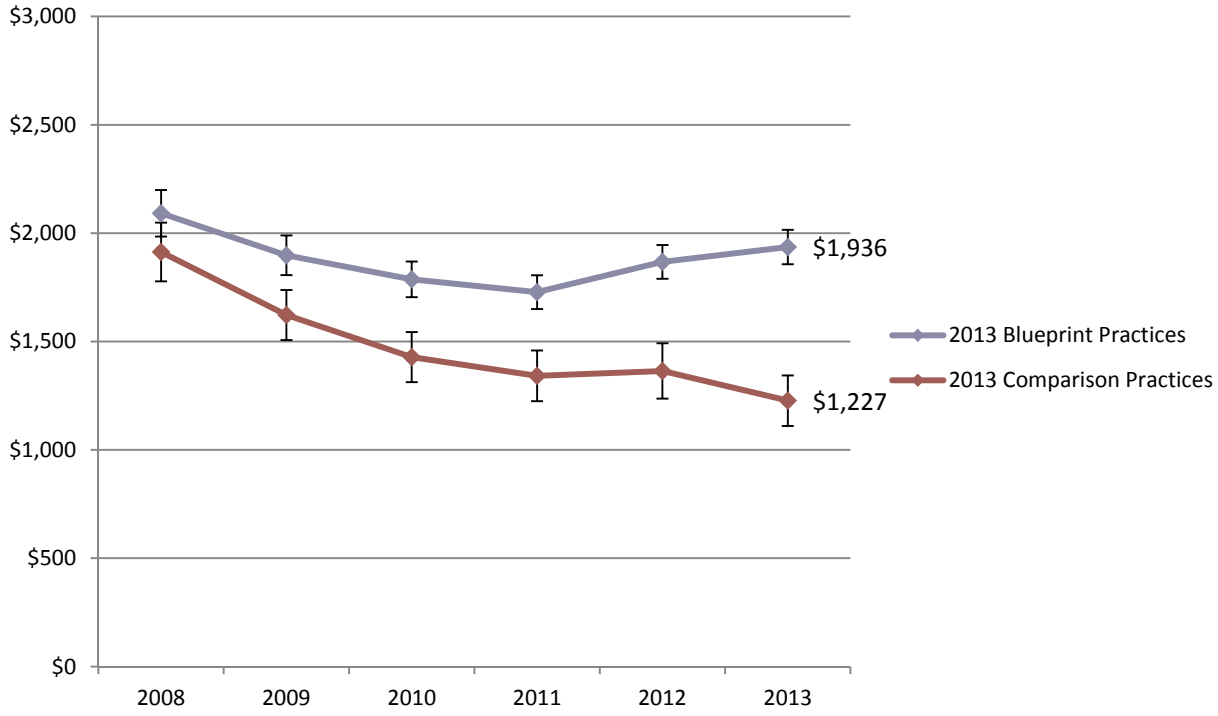


2.a.2. Special Medicaid Services (SMS)

During the same period of time, Medicaid beneficiaries receiving care in Blueprint Practices had higher rates of expenditures for Specialized Medicaid Services (SMS) including; Transportation, Home and community-based services, Case management, Dental, Residential treatment, Day treatment, Mental health facilities, and School-based and Department of Education Services

(Figure 5). These results suggest that the PCMH and CHT setting was associated with lower expenditures for traditional healthcare, and higher use of services targeted at social and economic disparities.

Figure 5. Total Expenditures Per Capita for Special Medicaid[5] Services Ages 18-64



2.b. Outcomes Summary

The difference in healthcare expenditures was driven by several factors including lower hospitalization rates and lower expenditures on pharmacy and specialty care. A composite measure of total utilization shows similar divergence between the participant and comparison groups, with the greatest separation from 2011 forward in concert with program expansion and maturation across the state. Emergency Department visits are one category of utilization that was not consistently better for participants. Despite lower expenditures, the results for measures of effective and preventive care were either better for participants or similar for both groups (cervical cancer screening, breast cancer screening, imaging studies for low back pain, and

[5] Special Medicaid Services (SMS), such as transportation, residential treatment, dental, and home and community based services.

recommended assessments for patients with diabetes). Overall, similarly favorable patterns were observed in the pediatric population.

2.c. Return on Investment

In 2013, lower healthcare expenditures for participants offset the payments that insurers made for medical homes and community health teams (Table 3). The results for 2012 also showed similar savings.

Table 3. Returns Versus Investments in Medical Homes and Community Health Teams

Results for Calendar Year 2013	Medicaid	Commercial
Number of Participating Beneficiaries	83,939	143,961
Total Medical Home Payments	$2,085,035	$3,576,002
Total CHT Payments	$2,343,603	$5,182,633
Total Investment Annual	$4,428,638	$8,758,635
Total Expenditures per Capita (participants)	$7,776	$4,954
Total Expenditures per Capita (comparison)	$7,877	$5,519
Differential per Capita (participant vs. comparison)	$101	$565
Total Differential (participants vs. comparison)	$8,477,839*	$81,337,965

**Includes expenditures for special Medicaid services (SMS)*

The figures included in Table 3 provide the gain-to-cost ratio for insurers and are not inclusive of all in-kind participation, Blueprint community grants, or other contributions. Overall, these results suggest a positive return on investment for insurance customers and better healthcare for Vermont's citizens. These results also provide an objective rationale for strengthening PCMH and CHT operations.

Most importantly, the results highlight that capitated population-based payments, which are targeted toward specific goals, in conjunction with transformation support through Blueprint grants, can lead to structural and behavioral changes in the healthcare delivery system that improve health services and cost outcomes.

While the results to date are favorable, additional financial and delivery system reforms are necessary in order to maintain progress, reduce the growth in costs, and improve care for Vermonters. The

Blueprint proposes to build on the existing foundation, integrate with Provider Networks, and establish an infrastructure to support future healthcare reforms in Vermont.

3. CURRENT PRIORITIES: A STRATEGIC PLAN FOR A MORE EFFECTIVE HEALTH SYSTEM

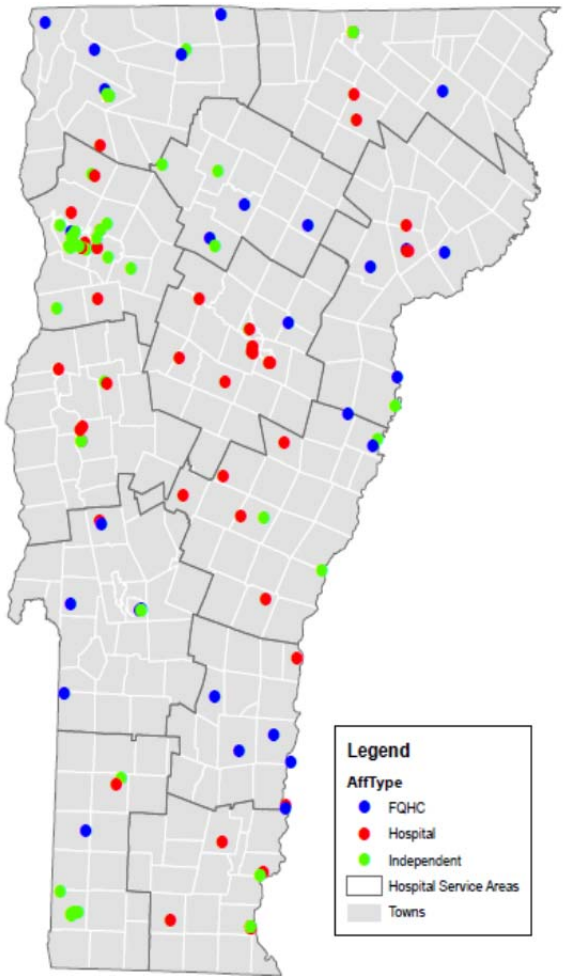
While the work towards a new financing structure for health care in Vermont has recently slowed, the opportunity to continue reforms of the payment and delivery systems continues unabated. New payment strategies are being tested as part of the Vermont Health Care Innovation Project (VHCIP) funded by the Center for Medicare and Medicaid Innovation (CMMI) through a State Innovation Model (SIM) grant such as shared savings plans, bundled payments and pay-for-performance models.

3.a. Formation of Provider Networks

A key new reform initiative is the formation of three Provider Neworks (also called Accountable Care Organizations or ACOs). Each Provider Network is a formal business arrangement of previously independent providers, with the shared purpose of organizing more effective care, improving quality, and achieving shared savings. The three Provider Networks in Vermont include: Hospitals and hospital affiliated practices (OneCare); Federally Qualified Health Centers (Community Health Accountable Care); and independent practices (Health First).

Blueprint PCMHs are affiliates in one of these new organizations (Figure 6). Each of the three Provider Networks (ACOs) has implemented governance structures and work groups for their constituents. The same constituents also participate in Blueprint governance and workgroups, which are organized by community and inclusive of all Provider Network practice types. Figure 6 shows the type of each of the Blueprint medical practices.

Figure 6. Medical Home Practice Sites by Affiliation



3.b. Aligning the Blueprint and the Provider Networks (ACOs)

The alignment work between the three Provider Networks (ACOs) and the Blueprint is central to a dynamic healthcare reform climate in the state, and positions Vermont to achieve the aims of providing all citizens with access to high-quality health services, improving the health of the population, and improving control over healthcare costs.

To move toward more advanced financing models, it is essential to continue to improve the delivery system in Vermont. The success of a new financing and payment system will ultimately depend on the quality and efficiency of the delivery system, including a strong foundation of primary care that has a central role in coordinating services of medical and non-medical providers. This section of the report focuses on a plan to advance Vermont's delivery system through a series of unifying actions that will:

- Strengthen community-oriented health systems

- Help ACOs achieve their goals
- Establish a better capability for rolling out new service models
- Enhance the use of data to guide service and quality improvement

3.c. Priority 1: Unified Community Health Systems

The Blueprint is based on a community-oriented structure designed to provide more effective health services across the population. Each health service area (HSA) has organizing meetings that include an extended group of medical and non-medical stakeholders, a Project Manager, community health team (CHT) leadership, Practice Facilitators, and self-management workshop regional coordinators and leaders. These meetings can also focus on collaborative learning activities.

Similarly, as the three Provider Networks are organizational in nature, they initially directed each of their Provider Networks to form local clinical working groups.

On the surface, it may appear that the purpose and focus of these Blueprint structures and Provider Network workgroups are distinct. Provider Network activities are oriented toward organizational goals including improved health services, achieving benchmarks for quality and healthcare, and qualification for shared savings. Blueprint activities are focused on community level operations including medical home status, integration of the CHT as a shared resource, strengthening of service networks, and quality initiatives that span all practice types. Despite these apparent differences, the work is oriented toward similar goals and objectives, and has the potential to be aligned and integrated. There exists an overarching set of shared interests including improving the quality of services available to patients and families, improving the health of the population, more effective healthcare utilization and a reduction in unnecessary care, and better control over growth in healthcare costs. For all involved, high quality primary care coordinating with other medical and social services is an essential ingredient to accomplishing these shared goals. The Blueprint and Provider Network leadership are proposing integrating activities in a way that will strengthen the community health system structure that spans all three Provider Networks, while helping each organization to achieve their respective goals.

In each Health Service Area (HSA), providers, Blueprint Project Managers, and Provider Network leadership are working together to merge their workgroups and collaborate with stakeholders to form a single unified community health system initiative. The collaborative will:

- Include medical and non-medical providers
- Have a local leadership team that balances the influence of participating providers
- Focus on local priorities and improving the results of VHCIP core ACO measures
- Support the introduction and extension of new service models

- Provide guidance for medical home and community health team operations

This approach will establish a data-guided community health system collaborative, result in more effective health and human services, and reduce the number of overlapping initiatives that currently exist. Existing Blueprint and VHCIP resources can support these collaboratives, including local Project Managers, Practice Facilitators, self-management programs, shared evaluation and comparative reporting, and shared learning forums.

Unified community collaboratives will be well positioned to roll out new service models in their community, whether those models focus on care standards, specific conditions, or complex situations related to health and human circumstances. The ability of the Blueprint to introduce and scale models has been demonstrated with medical home standards, community health team operations, condition-specific programs (like diabetes), self-management programs, the Hub & Spoke, and the Support and Services at Home (SASH) program[6].

Integration of payer, Blueprint, and Provider Network activities will enhance this capability, ensuring a common focus across a wider group of stakeholders and the use of common data for planning and assessment. There are a large number of potential priorities, including:

- Condition-oriented programs, such as cardiovascular disease, diabetes, or depression
- Programs oriented towards complex life circumstances that span health and human services, such as adverse childhood experiences, obesity, addiction, or complex trauma

Priority service models will emerge through activities with broad stakeholder input around community needs, Provider Network priorities, VHCIP workgroup initiatives, and policy. The goal of this plan is to establish unified community collaboratives that can efficiently scale priority service models as they are identified.

In some areas of the state, there has already been a move towards this blended community collaborative. In order to establish a statewide approach, the Blueprint team will work with payers, Provider Network leadership, and constituents around the state in order to:

- Adopt a generalized organizing framework, including a representative local leadership structure
- Plan the alignment of local collaborative activity with state-level collaborative activity involving Provider Network and Blueprint leadership teams

Mandated Blueprint leadership meetings, including those for the Executive Committee and the Planning and Evaluation Committee, will be oriented towards addressing the needs of these

[6]SASH helps seniors age safely at home by addressing a complex blend of medical and non-medical needs.

collaboratives. Blueprint grants to each HSA will be designed to support participation in the collaborative structure. The Blueprint's comparative evaluation and profiling capabilities will be extended to support ACO measurement needs through collaborative design.

Blueprint-sponsored learning collaboratives will be oriented towards the focus of these unified community collaboratives, including knowledge sharing around priority service models and improvement against core quality measures. It is important to note that SIM funds have also been provided to support this type of collaboration in developing the Provider Networks.

3.d. Priority 2: Unified Performance Reporting and Data Utility

There is an increasing use of data to guide health services, quality initiatives, and payment. Amongst states, Vermont is well positioned with a relatively mature all-payer claims database and a steadily expanding digital health information infrastructure. At the same time, there is increasing demand for meaningful and timely measurement and reporting to support the needs of providers, organizations, insurers, policy leaders, and other stakeholders.

A number of measurement and reporting activities have been developed in response to this demand, and they are at the heart of a movement towards a data-guided learning health system.

The Blueprint has made extensive use of the all-payer claims database for several purposes, including:

- Evaluation of the program's impact
- Generation of comparative outcomes profiles for practices, hospital service areas, and organizations

The use of all-payer claims data allows for measurement across an entire population, which is important for clinicians focused on improving services for everyone they care for (regardless of insurer). Substantial input from providers has helped to shape the format and output of the profiles, and the last year has seen substantial uptake in use of the profiles for evaluation and for planning quality initiatives at a local level.

Each profile contains detailed results, comparing a healthcare setting to its peers, on measures of utilization, expenditures, and quality. In this way, the profiles provide information on variation to practices, organizations, and hospital service areas. Understanding performance relative to peers, and the extent of variation, provides an evidence basis for identification of opportunities for improvement.

In parallel, Provider Networks have initiated efforts to produce results for core quality measures and to study variation of key outcomes across settings. This work aims to guide quality initiatives and to identify opportunities related to unnecessary utilization and expenditures.

Each Provider Network has had to aggregate and analyze data from various data sources –often for subsets of the population of interest to an insurer sponsoring a shared savings program, resulting in time-intensive data collection and measurement activity. Examples include data in the form of claims provided by an insurer or data gathered from administrative and clinical systems in hospitals, health centers, and practices. Most time intensive of all have been the chart reviews required to generate the clinical measures required by the Shared Savings Programs.

An opportunity exists for the Blueprint and Provider Networks to collaborate on measurement and reporting activities and to provide clinicians and unified community collaboratives with results that pertain to their overall populations.

Insurer, Blueprint, and Provider Network leadership are piloting a process to co-produce performance dashboards featuring core Provider Network measure results, as well as other analytics important to support care delivery transformation. These dashboards present population-level results and directly support the work of the unified community collaboratives. The dashboards will augment the suite of comparative profiles that are currently produced for practices, hospital service areas, and organizations, providing a focused set of measure results relevant to all entities participating in Provider Network activity.

This approach can be generalized to include sharing data sets, collaborating on analytic activity, and planning for an advanced digital health information infrastructure that can support the range of data needs for Vermont's health system.

The initial step is to co-produce profiles showing comparative results for the core ACO measures that are derived from claims data. These can be immediately produced as part of routine Blueprint analytics and provided in conjunction with the suite of profiles currently provided to practices, organizations, and service areas. Please refer to Section 7 for HSA Profiles for additional detail and for sample screenshots from the Barre HSA Profile.

These profiles and the measurement dashboards will directly support the work of the unified community collaboratives by providing comparative data for a range of important quality, utilization, and expenditure measures. Additional opportunities are being examined and piloted, including linking clinical and claims data producing results for measures reliant on clinical data, and sharing analytic data sets. Refer to Data Reports to Practices and HSAs starting in Section 7 for further information on in-progress analytic work being piloted through the Blueprint with Onpoint Health Data (Onpoint) and Vermont's Provider Networks.

With some exceptions, aggregation of clinical data to date has largely relied on chart review for providers, Provider Networks, and insurers. Exceptions include the ability for certain organizations to extract clinical data from their own Electronic Health Record (EHR) systems and a well-organized process for common measurement across Federally Qualified Health

Centers; however, it is still difficult to consistently measure clinical outcomes for a whole population in a service area or statewide.

Working with Vermont Information Technology Leaders (VITL), the Blueprint has been aggregating a subset of clinical data in a registry from a growing number of medical home sites across the state. As part of this effort, the Blueprint and VITL have initiated a structured effort to improve clinical data quality being transmitted from these source sites. These statewide data quality initiatives, known as Blueprint "Sprints," are discussed in detail in End-to-End Healthcare Information Transmission – Data Quality in Section 9.

The quality of the registry data has been verified in collaboration between Onpoint and the Blueprint Sprint technical project managers and has been used in the most recent round of HSA Profiles to measure key outcomes, including ACO quality measures. Onpoint also successfully linked the registry's clinical data with claims data, where patients had at least one claim and one clinical record within the 2013 measurement year. Please refer to HSA Profiles in Section 7 for an example of linkage between expenditures, hospital discharges, and emergency department visits of diabetics in control (based on hemoglobin A1c test results) versus those not in control.

The Blueprint is beginning work with Provider Network leadership to identify gaps in availability of clinical data and to guide data quality initiatives with practices and Provider Network partners across the state, since the ultimate goal is the production of core measure results for whole populations. Where appropriate, Blueprint and Provider Network leaders are considering opportunities to share analytic data sets (claims and clinical) in order to ensure efficiencies and reduce the data collection burden on Provider Networks and providers.

These activities will help to accomplish a number of important goals as Vermont's digital infrastructure continues to develop.

First, the culture of using data to guide change is being strengthened across the state at the practice, organization, and community levels. The availability of consistent measurement, across an entire population, is important to fuel this effort. Co-reporting of key measure results of common interest across all parties and the formation of the unified community collaboratives to focus on these measures will advance Vermont's progress towards a learning health system.

Second, testing the actual utility and quality of clinical data available through the health information infrastructure is helping to advance Vermont's health system in several ways. It will allow communities and organizations to use more advanced data to guide their efforts, inform collaborative data quality initiatives for VITL, Blueprint, Provider Networks, and others, and influence the development of Vermont's digital infrastructure by quantifying data gaps and quality needs. These efforts will help inform VITL as it continues to build data warehousing capabilities and positions itself as a source for the growing array of analytic needs.

In the end, analytic systems, such as those employed by Provider Networks, depend on a reliable source of clinical data with consistent quality across settings and organizations.

3.e. Priority 3: Options for Payment Modifications

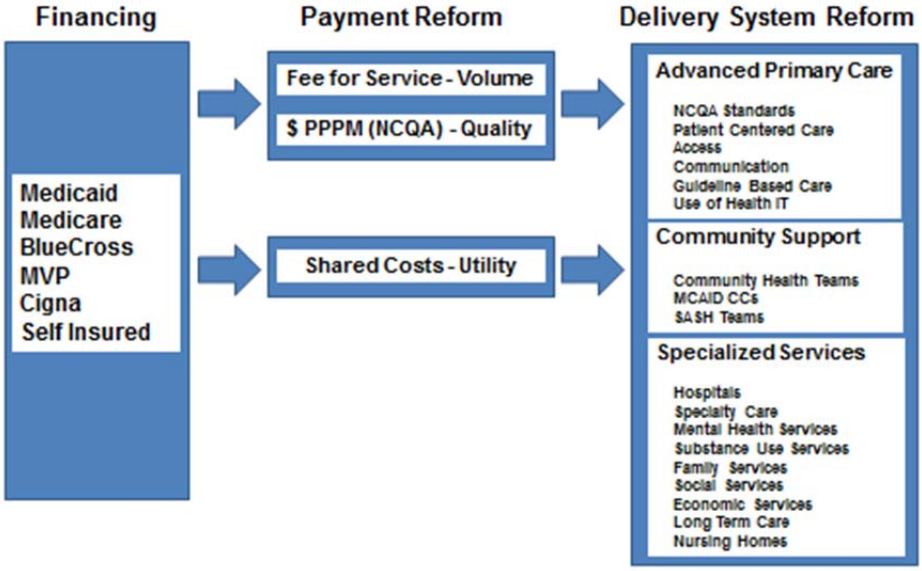
As of 2013, the two planned Blueprint payment reforms (for Transformation and Capacity) are implemented statewide and sustained through enacted Vermont statute. These financial reforms align fiscal incentives with healthcare goals. All major commercial insurers, Medicare, and Vermont Medicaid fully participate. These targeted payment streams are designed to achieve specific outcomes with clear incentive structures that promote the stated Blueprint goals, including quality, access, communication, and patient-centered services.

The two specific streams of enhanced financial support are as follows and are illustrated in Figure 7.

Transformation: Per Patient Per Month (PPPM) payments are based on the scoring level achieved by the primary care practice in NCQA-PCMH Recognition. This payment is quality-based, comes in addition to traditional fee-for-service (volume-based payments), and provides incentive to practices for quality. It promotes access, communication, guideline-based care, well-coordinated preventive health services, use of electronic tracking systems, and population management. This payment is sent directly to the practices.

Capacity: All insurers share the cost for core CHT members. Total support is provided at the rate of $70,000 (~1.0 FTE) / 4000 patients, which amounts to about $1.50 per patient per month. This capacity payment reform establishes a community-based care support infrastructure available to primary care practices and the general populations they serve. The CHT is supported 6 months prior to a practice's NCQA score date, further underscoring the Blueprint partners' commitment to the spread of quality improvement. This payment is routed to an administrative entity in each health service area to support community health team operations.

Figure 7. Blueprint Payment and Delivery System Reforms



The composite of these two payments, driving quality and capacity, was designed to build a foundation of more effective primary care with better social support services and better coordination with an extended array of community providers. These payments did not stimulate change in isolation. Additional support for local transformation was provided through Blueprint Health Service Area (HSA) grants to fund leadership and organization of activities at a community level. As discussed previously, local Blueprint and Provider Networks can build on this foundation to form a more complete community health system.

Although the Blueprint has stimulated positive changes, some practices may choose to discontinue their participation. The medical home payments and the CHT payments have remained static since 2008. Many practices say that the process of scoring for NCQA-PCMH recognition has improved their operations, while some practices perceive this activity as costing more than what the current PPPM payments cover and as increasing workload in an already stressful practice environment.

Ideally, additional multi-insurer investments in both areas – PCMHs and CHTs – coupled with changes in payment methods would ensure robust participation in the Blueprint and further enhance outcomes.

Accordingly, the Governor's budget proposal, submitted to the general assembly on January 15, 2015, invests over $4.5 million in state fiscal year 2016, more than doubling Medicaid's Blueprint provider contributions. In fiscal year 2016, the Governor's budget proposes increases for the community health team payments by $540,000, increases Medicaid's share of CHT payments by $470,000 to allow rebalancing among payers, and adds $3.5 million to medical

home payments and new payment innovations. When annualized, this would provide over $8 million in new funding to support provider payments through the Blueprint, beginning January 1, 2016. If this funding is supported by the legislature, the Blueprint would be able to increase both payments and provide some support for innovations in payment models.

It is also important to ensure improved financial participation from the other payers as well.

Medicare

Questions regarding CMS's continued participation was resolved in September when the U.S. Health and Human Services announced that Medicare will continue to support and participate in the Multi-payer Advanced Primary Care Practice (MAPCP) demonstration through December 31, 2016. Only those states with programs designed like Vermont's were extended. This extension serves as a strong positive signal that the demonstration, as implemented in Vermont through the Blueprint, has achieved some of the federal goals.

Commercial Insurers

The timing of the commercial insurance rate review process and Vermont's hospital budget process limits the state's ability to add additional funding in the current fiscal year. Calendar year 2015 insurance premiums have already been set by the Green Mountain Care Board (GMCB), and open enrollment for the individual and small group markets began in November 2014.

Increasing Blueprint payments in FY15 would have an impact on already approved insurance rates. In addition, the GMCB has already approved the Vermont hospitals' budgets for 2015. An increase in the Blueprint payments for primary care providers and CHT staff employed by a hospital would cause a disruption to the already approved budgets for these hospitals.

In order to ensure that payment modifications are appropriately reflected and considered in the regulatory process, the Governor's budget proposes that the new funds begin January 1, 2016.

3.e.1. Change Share of Each Insurer's CHT Costs to be Proportional to Market Share in Vermont

When the Blueprint program was established, community health team costs were divided among the 5 major insurers in Vermont:

- MVP Healthcare
- Blue Cross Blue Shield of Vermont
- Cigna
- Medicaid
- Medicare (through the MAPCP demonstration as of 2011)

Costs were divided evenly, with some adjustment for the insurer with the lowest market share, as the intent was to treat the teams as a shared resource available to all medical home patients. As

the Blueprint program has expanded, there have been substantial changes in Vermont with regards to insurer market share. One adjustment to insurer cost allocation was made when a particularly large account shifted from one commercial insurer to another. Substantive shifts have continued in both the commercial and Medicaid market share with the implementation of the Affordable Care Act.

With the Blueprint program expanded statewide to the majority of primary care practices and all health service areas, it is important to consider a community health team (CHT) cost structure more reflective of the direction of Vermont's health insurance market. At this time, the direction is towards three dominant insurers, leaving two insurers paying a share of CHT costs that is out of proportion with their market share.

Proposed is a cost structure that aligns each insurer's share of CHT costs to their share of the attributed medical home population, as the population with the most direct access to CHTs. Each insurer's share of costs should be adjusted based on a routine assessment of their attributed medical home market share. To ensure a transparent and objective assessment, attributed medical home market share should be determined using consistent methodology applied to data in Vermont's all-payer claims database. The redistribution of CHT allocations is represented in Table 4 below.

Table 4. Proposed Change to Align Community Health Team Share with Insurer Market Share

	Current share of CHT Costs	Proposed share of CHT Costs*
Medicare	22.22%	22.22%
Medicaid	24.22%	35.66%
BCBS	24.22%	36.92%
MVP	11.12%	4.71%
Cigna	18.22%	0.49%
Total	100.00%	100.00%

**These percentages are based on insurer reported number of patients attributed to patient centered medical homes participating in the Blueprint.*

Under 18 VSA 706(c), in order for any new strategy to be adopted, the Blueprint Expansion Design and Evaluation committee must first recommend a new approach to attribution. If the committee makes this recommendation, the Director of the Blueprint for Health may work with private insurers to implement the new attribution methodology. Any Medicaid participation, however, is subject to appropriation and may not be implemented in the same manner. The Governor's budget proposal includes $470,000 in funding for fiscal year 2016 ($940,000

annually) for Medicaid to increase its contribution and ensure that the state participates in this manner.

Medicare's share is held constant in this example, since their level of participation and funding contributions remain outside the reach of Vermont policy. Additionally, their current share is in reasonable alignment with their attributed market share of the medical home population. If this strategy is implemented, then a proposal will be made to CMS to participate as part of the Multi-Payer Advanced Primary Care (MAPCP) demonstration, the program through which Medicare participates in the Blueprint model.

3.e.2. Increase Both Community Health Team and Medical Home Payments

Within the Blueprint program, the combination of the medical home and community health team represents the model that has been evaluated and has demonstrated favorable outcomes in Vermont, and it is thus not possible to tease out the incremental impact of either of these components in isolation. There is a rationale for further investment in the complete model given the improvements in healthcare utilization, expenditures, and quality and the appearance of diverging trends between the participant and comparison groups.

As Blueprint and Provider Network activities are integrated in each community, this option would most likely stimulate the strongest unified health system and would add the greatest capacity to extend new priority service models. This level of investment also represents the greatest financial challenge in a tight fiscal environment.

Increase Community Health Team Payments

Community health teams (CHTs) provide the medical home population with direct access to multi-disciplinary staff, such as nurse care coordinators, social workers, dieticians, and health educators. There is no cost-sharing or prior authorization for patients referred to CHTs, and they can be connected with appropriate CHT staff based on need and clinical judgment.

The CHT is considered a distinguishing characteristic of Vermont's medical home model. Increasing the capacity of these teams can directly support new service models for targeted needs, such as cardiovascular disease, mental health, addiction, trauma, and adverse childhood experiences. A recent example is the addition of staff to CHTs to enhance treatment capacity for opiate addiction as part of the Hub & Spoke program, demonstrating rapid statewide rollout of a standardized treatment program targeting a high priority need.

Increasing CHT payments will most immediately increase the effectiveness of the unified community health services model through improved control of chronic conditions and will help Vermonters live healthier lifestyles that prevent common health conditions.

Examples are provided in the *Blueprint for Health Report: Medical Homes, Teams and Community Health Systems* was published October, 2014 showing the financial impact of increasing the CHT payments.

Medical Home Payments

As discussed previously, medical home payments, and access to CHT staff, have helped to engage the majority of primary care practices in Vermont in the process of preparation and scoring against the NCQA medical home standards (Figure 7.1 Executive Summary).

The national standards for NCQA-PCMH recognition have been revised every three years and are increasingly rigorous in their requirements for primary care practices to demonstrate high-quality, patient-centered, well-coordinated preventive care. This option would help ensure continued participation in the Blueprint and enhance capacity for primary care practices to apply the increased standards.

An additional investment in medical home payments helps ensure that Vermonters have access to primary care in accordance with NCQA standards and direct access to CHT staff. Vermont is currently well-positioned with a replicable and scalable process for helping practices prepare for scoring, undergo objective and independent scoring, and participate in initiatives for ongoing quality improvement. In concert with increasingly rigorous standards, maintaining the current level of practice participation and continuous improvement makes it more likely that Vermont will have a strong primary care base to underpin future healthcare reform efforts and goals. If this option were implemented, the increase in overall payments and the cost impact for each insurer is shown in Table 5.

The Governor's proposed budget provides for funding sufficient to implement this proposal, as well as to invest in the alternatives discussed below. Flexibility in increasing the payment should be provided in order to allow additional time to design an increase in the medical home payment with new capitated payment described below.

Table 5. Increase Medical Home Payments to Average of $4.00 to $5.00 PPPM

Insurer	Current PCMH Cost (annual)	Proposed PCMH & CHT Cost (annual)	Differential (annual)
Medicare	$1,549,949	$1,549,949	$0
Medicaid	$2,085,035	$4,170,070	$2,085,035
BCBS	$2,345,330	$4,690,660	$2,345,330
MVP	$404,000	$808,000	$404,000
Cigna	$826,672	$1,653,344	$826,672
Total	$7,210,986	$12,872,023	$5,661,037

3.e.3. Change the Medical Home Payment Methods

The medical home and the community health team payments represent a blend of capitated payment (quality + capacity) designed to stimulate targeted transformation goals. This approach has led to statewide medical homes and community health teams with evidence of improved outcomes for patients.

Under development is a new model for medical home payments that aligns financial incentives with the goals of the UCCs and provider networks. Alignment is accomplished thru a shift in emphasis from payments based on process measures (NCQA recognition) to a composite that includes outcome measures which directly correlate with the goals of Vermont's health reforms. The outcomes or performance-based payments, one focused on a combination of ACO quality measures another on total utilization, would be based on the performance of the HSA. Aligning the payments with the ACO measures and total utilization, and basing them on HSA performance, supports the work of the unified community collaboratives. The ability for a unified community health collaborative involving all Provider Networks and the Blueprint to drive improvement based on specific measures would serve as an important step toward a high-value health system.

The shift in the payments also aligns with broader health care reform initiatives, including the VHCIP's work plan to test new payment methodologies, including pay-for-performance.

The Blueprint, in collaboration with the ACO Provider Networks and the VCHIP team, will bring forward a detailed proposal for an outcomes-based capitated payment in early 2015. There is funding proposed in the Governor's budget, which could support this initiative.

3.e.4. Explore the Medicaid Health Home.

Under the Affordable Care Act, the federal government authorized a regulatory pathway to support Medicaid Health Homes, which includes enhanced 90/10 federal funding over 8 consecutive quarters for six core services provided to patients who meet complexity criteria. To participate, a state must seek a State Plan Amendment (SPA) approval and agree to quality and financial reporting requirements. Vermont has received SPA approval for a small health home program to fund the Hub & Spoke (Care Alliance) for opioid addiction treatment. Exploration is underway to identify how to leverage Health Homes funding to implement service models to address State and community priorities. Additional analysis will be done in order to ensure implementation of this option remains consistent with Vermont's current health care reform priorities. If approved, this funding would only be available for two years.

3.f. Moving Forward

The Blueprint program has stimulated a statewide foundation of medical homes and community health teams, which increasingly demonstrate improved outcomes on measures of healthcare utilization and healthcare expenditures. Three independent Provider Networks (ACOs) have formed to represent respectively hospital-affiliated, health center affiliated, and independent practices. The Blueprint has proposed a plan for integration of Blueprint and Provider Networks activities, advancement toward more unified community health systems, and options for enhanced payments to NCQA-PCMH recognized primary care practices and community health team staffing and operations. .

Important progress has been made on the proposed plan in the last few months of 2014. At this time, several communities have already started to integrate Blueprint and Provider Networks activities where common interests were evident. Support for this approach is widespread amongst Blueprint and ACO participants, and the participants are moving forward with detailed planning, including working out the specifics of a shared governance structure, shared reporting of core ACO measures, and development of whole population profiles, as well as other measures and data sharing.

In addition, possible administrative simplifications are being evaluated by state staff, in particular whether state quality requirements for participation in the Blueprint program may be aligned and streamlined given the NCQA quality requirements. Review and planning for this process is in progress.

The Director of the Blueprint and the Chair of the Green Mountain Care Board have worked closely together on defining the priorities in this section of the report. This process has helped to clarify the ways in which the Blueprint can support the work of the Board and future planned healthcare reform efforts. In particular, the existing Blueprint infrastructure adds capacity in the areas of quality standards, health service models, measurement, and model implementation in collaboration with community Provider Networks.

With regards to payment modifications, commercial insurers and Medicaid have been in detailed discussions with the Blueprint leadership team regarding program results and payment options. These discussions have also been held in the Blueprints public meetings involving a wide range of stakeholders, including the Executive Committee and the Planning Design and Evaluation Committee.

While there is broad acknowledgement of the need for payment modification and the value of the Blueprint program, commercial insurers have expressed the need to accommodate any financial changes through their internal budget planning process and the rate approval processes with the Green Mountain Care Board.

A strong foundation of primary care and social support services is considered an essential ingredient for a high-value health system in countries around the world, despite various forms of coverage, financing, and payment. Vermont's commitment to this difficult and unglamorous work has been extraordinary, as evidenced by the wide range of stakeholders in each area of the state that work together every day, participating in medical home, community health team, and Provider Network (ACO) operations, and remain committed to the shared vision of providing the best health services to all citizens in their communities.

4. INDIVIDUAL HEALTH SERVICE AREA (HSA) SNAPSHOTS

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

Each HSA has an Administrative Entity that leads the Blueprint locally. Generally, the Blueprint Administrative Entity is the local community hospital, though in some cases it is the Federally Qualified Health Center (FQHC) or Community Mental Health Center, based on the characteristics of the HSA. These organizations are responsible for local implementation of the Blueprint, including financial management of the program.

It is noteworthy that every HSA, through the administrative entity and partner organizations, has contributed its own financial and human resources, sharing in the effort to provide improved quality health care. This level of commitment illustrates the community-based undertaking involved in implementing and sustaining the Blueprint model statewide and is essential to its success.

Each Administrative Entity hires a Blueprint Project Manager, a local leader in the community and surrounding area. He or she is responsible for the Blueprint implementation, including:

- Working with the community to determine the design and functions of the CHT
- Facilitating CHT, extended CHT, and other community-based forums
- Working closely with Vermont Information Technology Leaders (VITL) to organize efforts to connect practices to the Vermont Health Information Exchange (VHIE) and the central clinical registry (DocSite)
- Developing relationships with local buprenorphine providers to support service improvements for treating opioid addiction
- Staffing support and guidance for the Unified Community Collaboratives

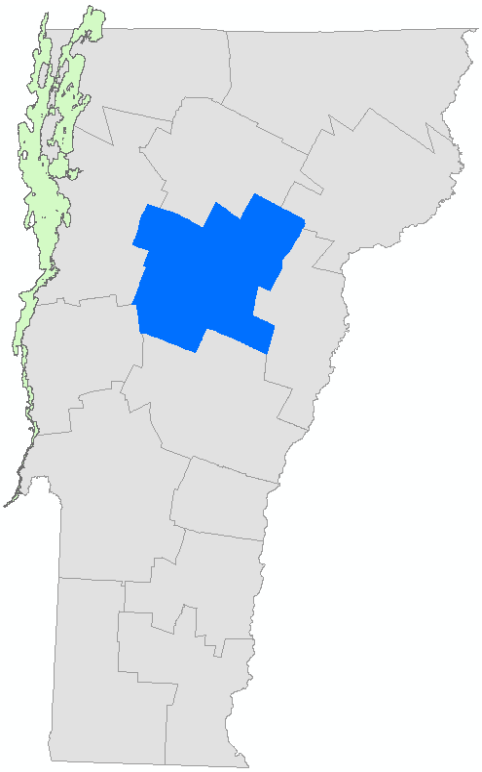
The following pages illustrate local efforts, allowing the reader to see both commonality between communities and the local flavor of the Blueprint. Individual "snapshots" provide a one-page summary of facts about and 2014 activities within each HSA, including.

- Name of HSA
- Name of Project Manager
- Vermont map showing location of HSA in dark blue
- "At a Glance" section, including:
  - Number of practices recognized as PCMHs
  - Total unique patients served by those practices
  - Number of FTEs staffed as CHT members
  - Number of self-management workshops offered and number of participants
  - Number of SASH teams and participants served

- 2014 Highlights
- Chart depicting:
  - Number and types of recognized advanced primary care practices
  - Type of CHT staffing in number of FTEs
- List of named Blueprint recognized medical homes (PCMH) in each HSA

Barre Health Service Area

Project Manager - Mark Young, RN



At A Glance

12 practices recognized as Patient-Centered Medical Homes

58,229 Vermonters seen by Blueprint practices in the past two years

15 FTE Community Health Team staff

4.3 FTE Spoke staff

28 Community Self-Management Workshops offered

5.5 SASH Teams; 395 participants

2014 Highlights

We integrated Behavioral Health into Primary Care by creating a Trauma Screening Pilot and were awarded grant funding to begin providing Screening, Brief Intervention, and Referral to Treatment (SBIRT) in our medical homes, which will allow us to better address substance and alcohol misuse for patients in the primary care setting.

MAT Team is fully staffed and supports many patients with opiate addiction.

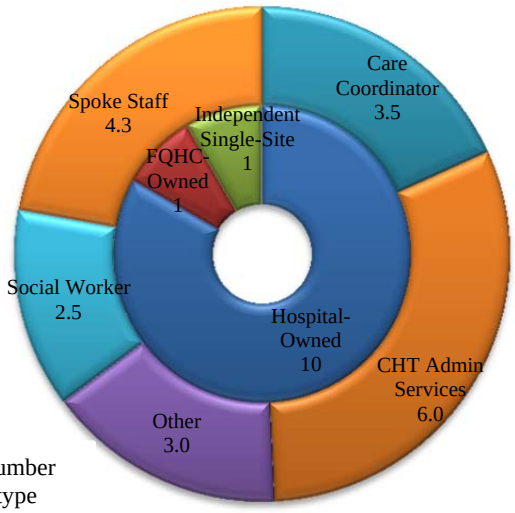
Panel Management efforts for Diabetic and Hypertensive patients have resulted in sustained improvement of patient care and clinical outcomes. Over 90% of our diabetic patients have had a current HbA1C, which has been consistent throughout each 2014 measurement period. Over 80% of our Hypertensive patients have a current blood pressure reading documented. Over 84% of hypertensive patients have their last blood pressure documented as "in control."

The CHT received 2067 referrals in 2014.

Medical Home Practices

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

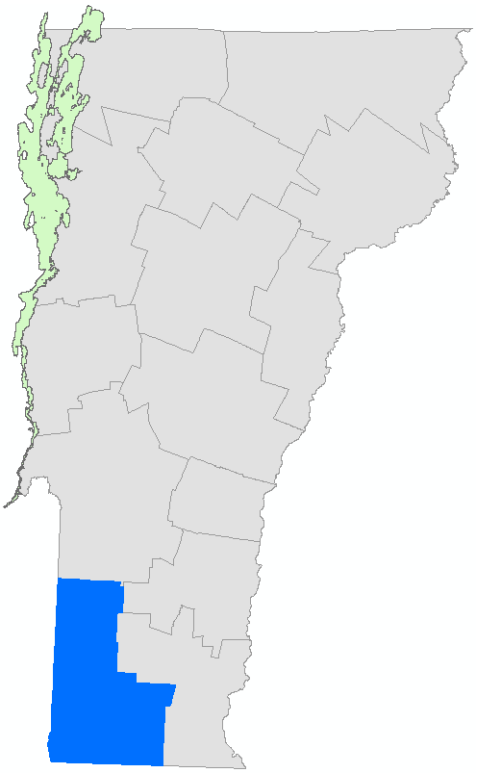
Barre



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

Bennington Health Service Area

Project Manager – Jennifer Fels



At A Glance

10 practices recognized as Patient-Centered Medical Homes

21,987 Vermonters seen by Blueprint practices in the past two years

7.5 FTE Community Health Team staff

2.4 FTE Spoke Staff

15 Community Self-Management Workshops offered

3.0 SASH Teams; 247 participants

2014 Highlights

Strategic Initiatives for Heart Failure, COPD and Pharmacist Services has resulted in best practices for implementation in primary care settings. These initiatives involved partners from across care settings, including staff from Blueprint practices.

Two new providers at the Hawthorne Recovery Center have expanded the capacity of Spoke Services.

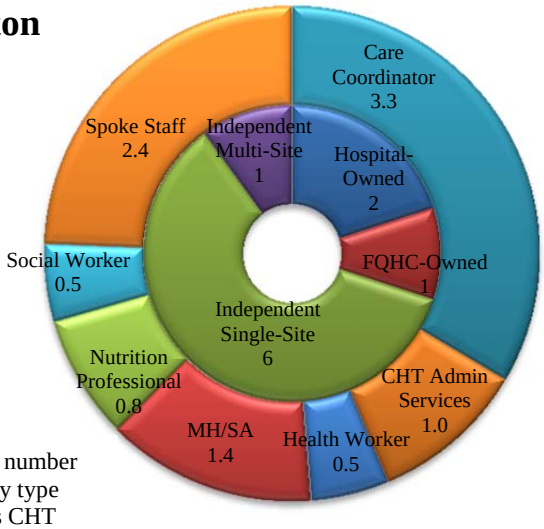
A new process to register SASH participants now enables communication between SASH Coordinators and hospital-based case managers. When a SASH participant has a hospital Emergency Department visit or hospital admission, a transition plan for the patient is started in collaboration with the SASH Coordinator.

The Bennington CHT had contact with 3,378 patients from October 2013 through September 2014.

Medical Home Practices

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

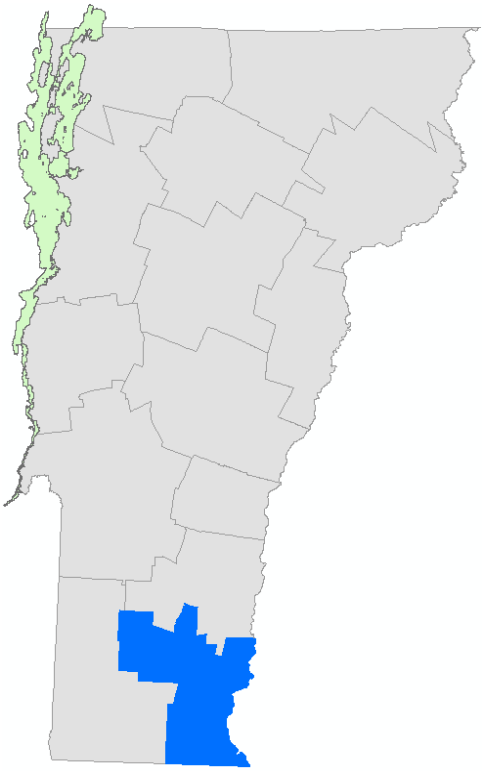
Bennington



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

Brattleboro Health Service Area

Project Manager – Wendy Cornwell



At A Glance

9 practices recognized as Patient- Centered Medical Homes

21,923 Vermonters seen by Blueprint practices in the past two years

8.5 FTE Community Health Team staff members
4.5 FTE Spoke staff

29 Community Self-Management Workshops offered in 2014

3 SASH Teams; 215 participants

2014 Highlights

The CHT's Certified RN Diabetic Educator and Certified Diabetes Educator/Nutritionist were recognized for the delivery of excellence in diabetes care.

The CHT worked with a total of 447 patients in 2014.

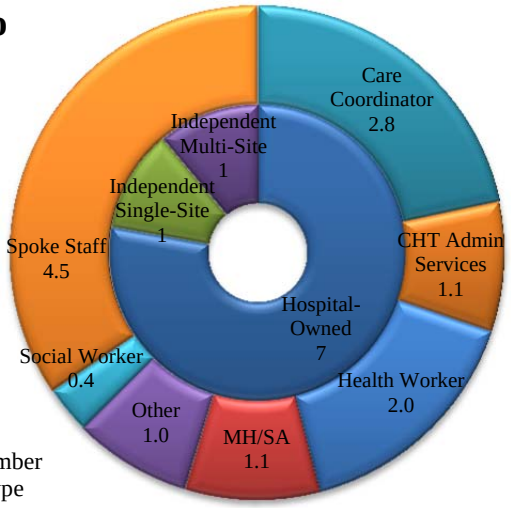
Substance abuse/opioid addiction and Hub & Spoke training were provided to the Medical Staff, the BMH Board of Directors, and the community.

The CHT is working closely with SASH, the Brattleboro Housing Authority, and the Co-op to bring self-management and healthier eating/cooking workshops to their residents and the community at large.

Medical Home Practices

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

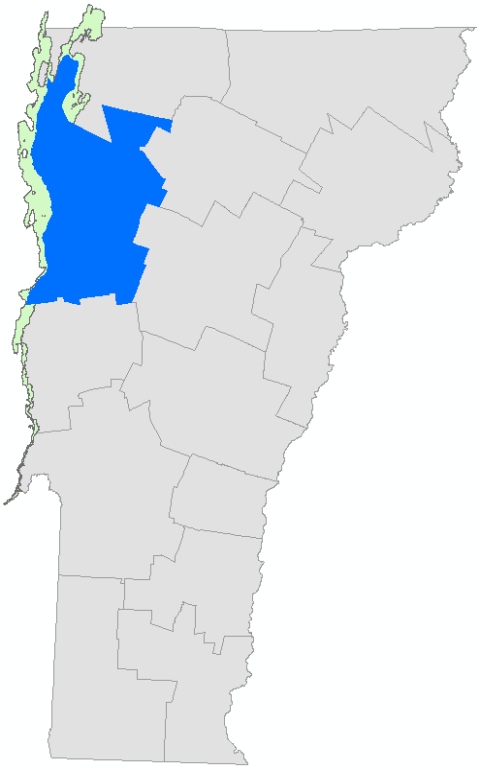
Brattleboro



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

Burlington Health Service Area

Project Managers – Deb Andrews, Penrose Jackson



At A Glance

27 practices recognized as Patient-Centered Medical Homes

155,803 Vermonters seen by Blueprint practices in the past two years

39.5 FTE Community Health Team staff members

8.2 FTE Spoke staff

33 Community Self-Management workshops offered

17 SASH Teams; 1614 participants

2014 Highlights

296 people participated in evidence-based self-management programs provided at 16 unique community sites across Chittenden County with a total of 22 workshops conducted.

Currently, we have 29 MAT practices serving 408 patients.

130 people were provided tobacco cessation counseling and support.

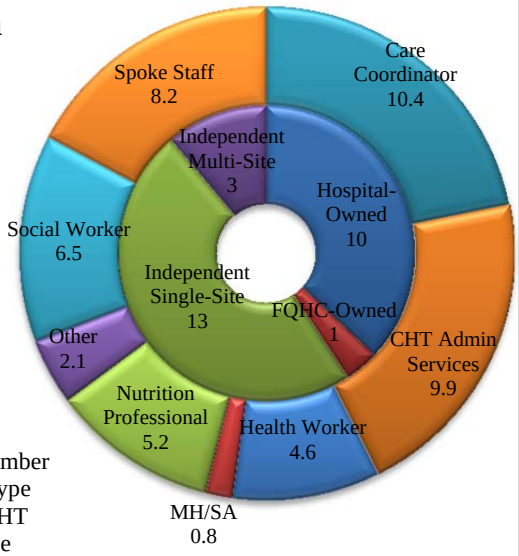
CHT patients referred for exercise and nutrition-related issues had a sustained improvement at the 6-month check in: BMI reduced by 57%, LDL by 34.6%

Implemented the first work group between the CHT, Spokes, and Rapid Intervention Community Court (RICC) to provide social and medical intervention in lieu of prison, along with ensuring patients have a medical home.

Medical Home Practices

Alderbrook Family Health
Burlington Primary Care
Charlotte Health Center
Christopher Hebert, MD
Community Health Centers of Burlington
Essex Pediatrics
Evergreen Family Health
Eugene Moore, MD
Frank Landry MD
Good Health
Hagan and Rinehart Pediatrics
Mountain View Natural Medicine
Richmond Family Medicine
Timberlane Pediatrics North
Timberlane Pediatrics
Thomas Chittenden Health Care
UVMMC Adult Primary Care Burlington
UVMMC Adult Primary Care S. Burlington
UVMMC Adult Primary Care Williston
UVMMC Adult Primary Care Essex
UVMMC Family Medicine Colchester
UVMMC Family Medicine Hinesburg
UVMMC Family Medicine Milton
UVMMC Family Medicine S. Burlington
UVMMC Pediatrics Primary Care Burlington
UVMMC Pediatrics Primary Care Williston
Winooski Family Health

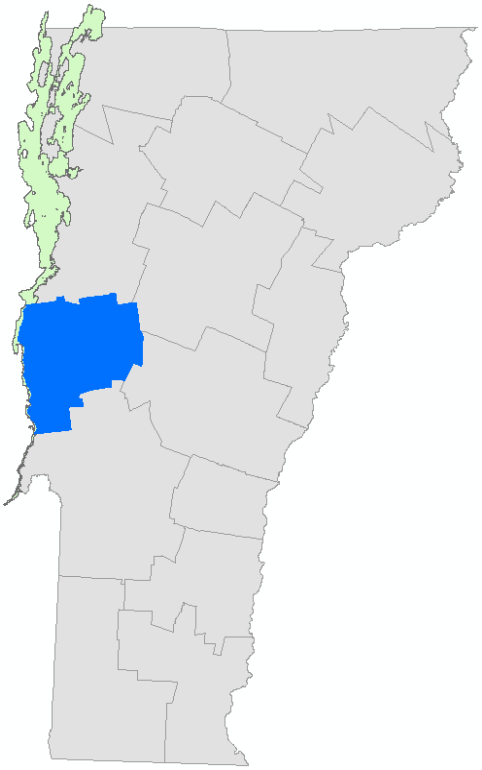
Burlington



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

Middlebury Health Service Area

Project Manager – Susan Bruce



At A Glance

9 practices recognized as Patient-Centered Medical Homes

28,319 Vermonters seen by Blueprint practices in the past two years

8.4 FTE Community Health Team staff

1.0 FTE Spoke staff

9 Community Self-Management Workshops offered

3.5 SASH Teams; 204 participants

2014 Highlights

Implemented the Spoke/OBOT program and worked collaboratively with the practice and community partners to build the infrastructure to support it:

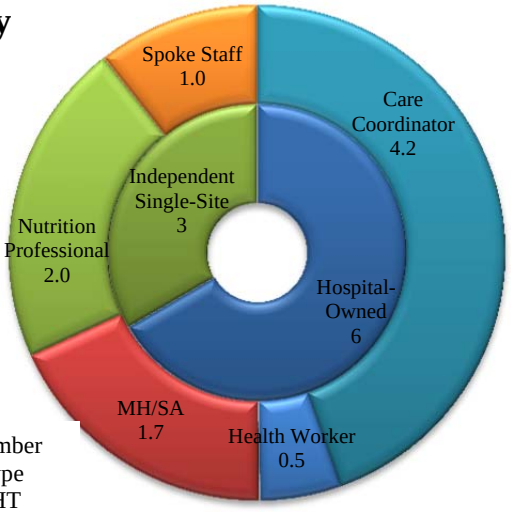
- Three out of the four practice providers are prescribing
- Hired and integrated MAT staff into practice (LADC & RN Case Manager)
- We are currently accepting patients from Hubs and are on track to be serving approximately 65 patients in the program by the end of March 2015.

CHT staff, providers and office staff began publishing a quarterly newsletter for families, which includes articles about nutrition, stress management, education regarding developmental information, and community resources.

Medical Home Practices

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

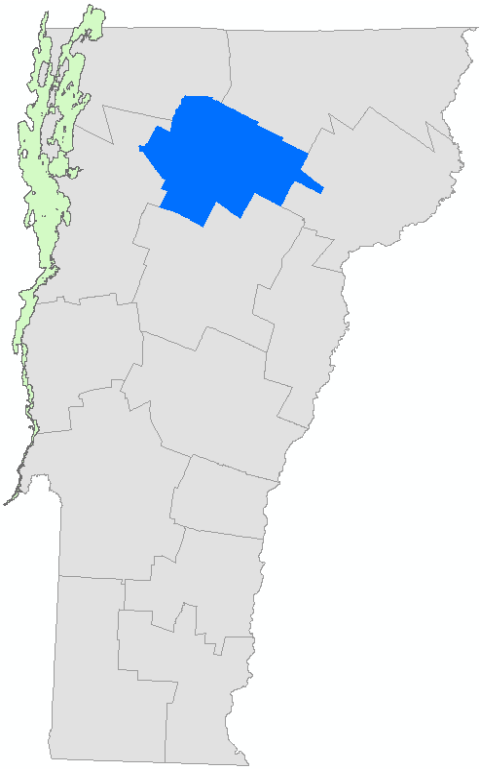
Middlebury



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

Morrisville Health Service Area

Project Manager – Elise McKenna, RN, MPH



At A Glance

6 Practices are recognized as Patient-Centered Medical Homes

30,657 Vermonters seen by Blueprint practices in the past 2 years

6.4 FTE Community Health Team staff

4.6 FTE Spoke staff

13 Community Self-Management workshops offered

1.0 SASH Teams; 87 participants

2014 Highlights

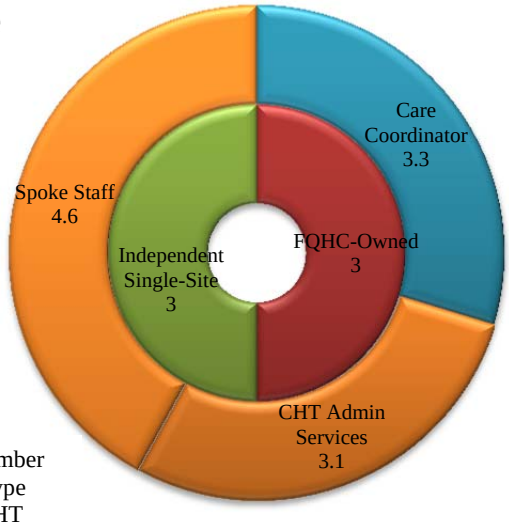
The HSA started regular Regional Clinical Planning Committee (RCPC) meetings to address ACO measures for participating members.

The Extended CHT and RCPC started an initiative on reducing hospital admission rates, targeting high-risk diagnoses on discharge by offering care coordination to the patient and involving the primary care physician in medication reconciliation and follow-up appointments.

A partnership between the MAT team and Copley Hospital created the "Close to Home" program for pregnant mothers addicted to opiates with the first delivery occurring in October 2014.

The CHT team at each medical home in the HSA implemented an emergency department (ED) utilization initiative, focusing on patients seen in the ED more than 3 times in one quarter.

Morrisville



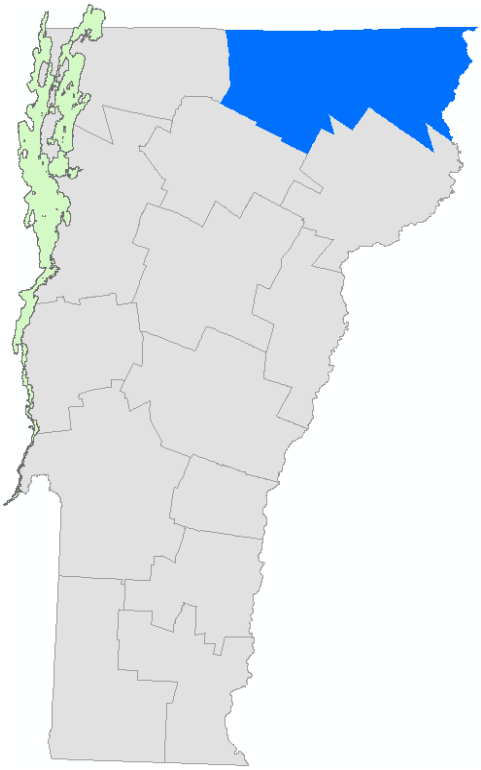
Inner ring is number of practices by type
Outer ring is CHT FTE by staff type

Medical Home Practices

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

Newport Health Service Area

Project Manager – Julie Riffon, RN



At A Glance

6 practices recognized as Patient-Centered Medical Homes

22,048 Vermonters seen by Blueprint in the past 2 years

4.7 FTE Community Health Team staff

7 Self-Management Workshops offered

3.5 SASH Teams; 211 participants

2014 Highlights

Implementation of MAT program in collaboration with St Johnsbury HSA

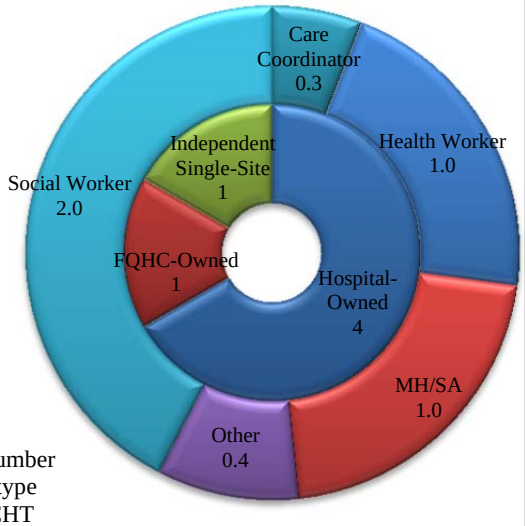
CHT staff provided dietician, medical social work, or chronic care coordination services to 865 patients.

CHT staff developed and implemented a new electronic Self-Management Care Plan module in the EHR for high-risk patients to meet the new 2014 NCQA PCMH standards.

Navigators funded by the Blueprint grant provided outreach activities to 1162 people and enrolled 1263 people in Vermont Health Connect

North Country Hospital participated as a pilot site for VITL-Access provider portal project, which implemented a process to capture patient consents for patients receiving care in area primary care practices and the emergency department, resulting in improvement of our area's ability to care for patients in either location.

Newport



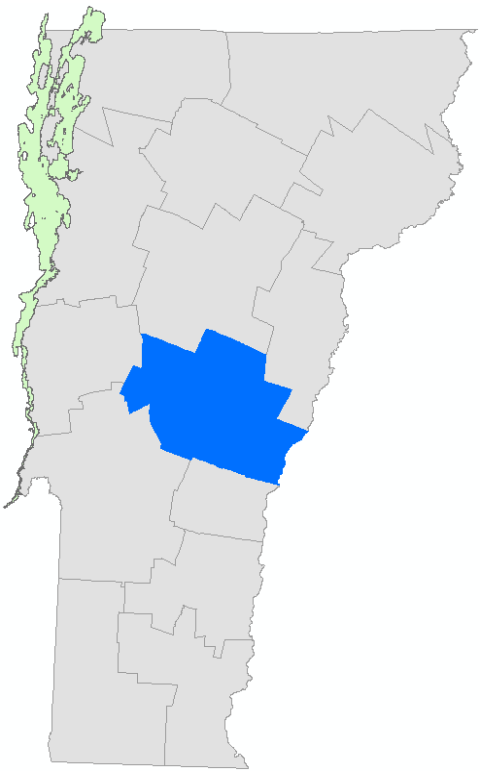
Inner ring is number of practices by type
Outer ring is CHT FTE by staff type

Medical Home Practices

Community Medical Associates – Newport
Family Practice of Newport
Island Pond Health Center
Newport Pediatric and Adolescent Medicine
Orleans Family Medicine
The Barton Clinic

Randolph Health Service Area

Project Manager – Mike Landon, MS



At A Glance

7 practices recognized as Patient-Centered Medical Homes

24,548 Vermonters seen by Blueprint practices in the past two years

3.3 FTE Community Health Team staff

1.8 FTE Spoke staff

13 Community Self-Management Workshops offered

2.0 SASH Teams; 90 participants

2014 Highlights

The Randolph HSA saw successful NCQA scoring for participating Primary Care Medical Homes and continued to provide and support collaborative, integrated care coordination.

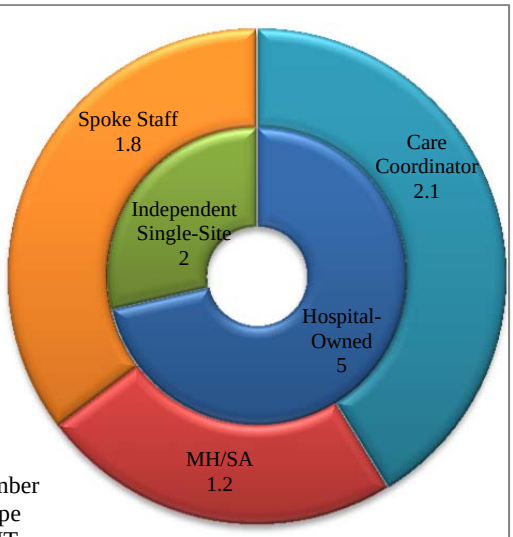
The entire area extends gratitude to LaRae Francis for her outstanding service as Blueprint Project Manager over the years. A new project manager, Mike Landon, was recruited and hired, in addition to a new CHT Leader/Nurse Care Coordinator, Lisa Delegato, RN.

An inventory of behavioral health resources was conducted for the Hartford Area, along with process improvement work related to transportation assistance.

Medical Home Practices

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

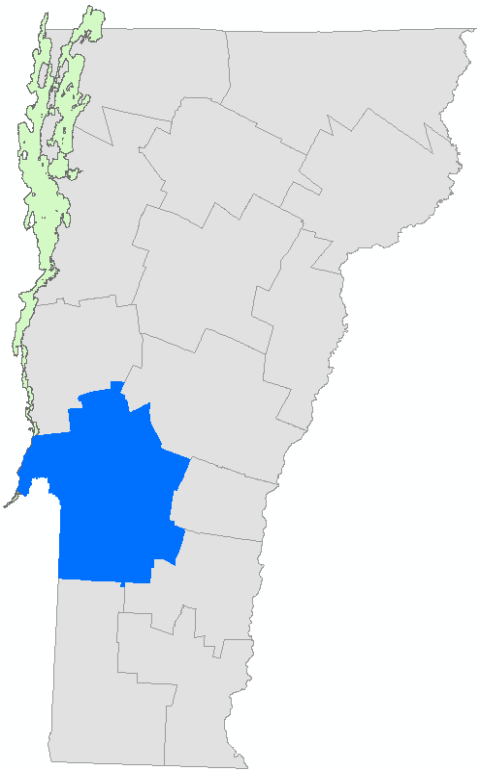
Randolph



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

Rutland Health Service Area

Project Manager – Sarah Narkewicz, RN



At A Glance

7 practices recognized as Patient-Centered Medical Homes

47,404 Vermonters seen by Blueprint practices in the past two years

12.1 FTE Community Health Team staff

3.2 FTE Spoke staff

48 Community Self-Management Workshops offered

5.0 SASH Teams; 427 participants

2014 Highlights

The 3 Core CHT case managers received 458 referrals in a 12 month period.

Hypertension project targeted patients with blood pressure (BP) >140/90 and focused on BP measurement accuracy, home BP monitoring, implementing protocols, use of EHR to identify patients, and improving patient self-management.

4 practices renewed their PCMH status and achieved Level 3 recognition.

Practices participated in the Asthma, Cancer, Pediatric, and MAT Collaboratives.

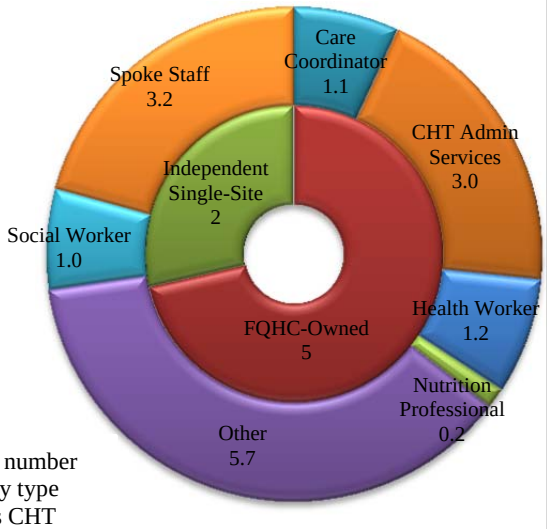
800 patients were referred to the tobacco cessation program, while 272 initiated the program and 190 completed the program.

Pediatric In Home Asthma Intervention visited 77 homes to assess the home environment and provide asthma education and environmental trigger reduction products.

Medical Home Practices

Brandon Medical Center
Castleton Family Health Center
Community Health Center of the Rutland
Pediatric Associates
Drs. Peter and Lisa Hogenkamp
Marble Valley Health Works
Mettowee Valley Family Health Center
Rutland Community Health Center

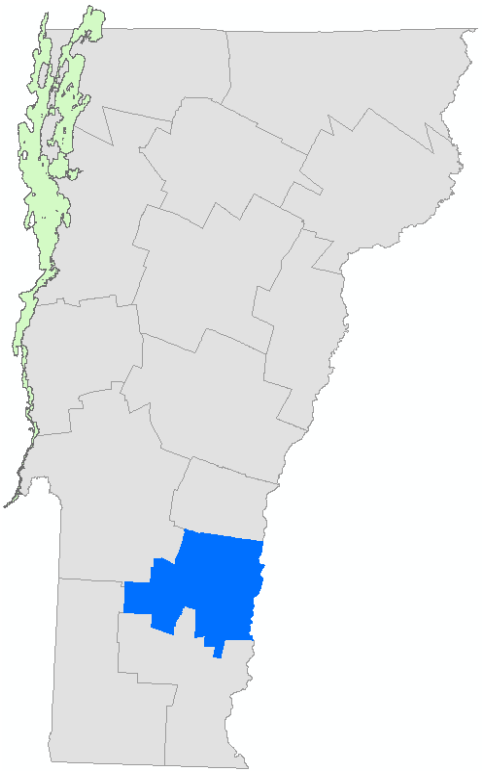
Rutland



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

Springfield Health Service Area

Project Manager – Josh Dufresne, MBA



At A Glance

5 practices recognized as Patient-Centered Medical Homes

25,686 Vermonters seen by Blueprint practices in the past two years

6.1 FTE Community Health Team staff

1.0 FTE Spoke staff

7 Community Self-Management Workshops offered

1.0 SASH Team; 116 participants

2014 Highlights

The CHT rolled out the grant-funded HealthTransit program in January, a community effort to address gaps in transportation for medical and wellness needs.

In collaboration with Connectivity River Transit, the HealthTransit program provided transportation to 255 individuals on 1050 trips over 32,000 miles for a total cost under $15,000.

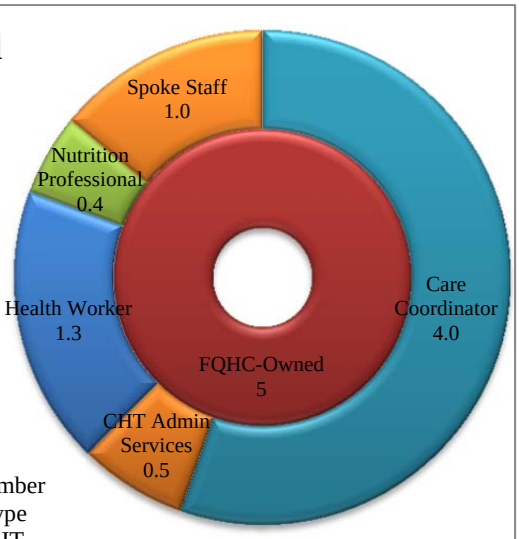
New CHT position focused on health access was created, which provides prospective patients with direct support finding PCPs and CHT services prior to their first physician visit.

20-plus community organizations attend monthly CHT meetings.

CHT involved in 25 community boards and committees, including the Springfield Warming Shelter.

To date, CHT has received 1167 referrals.

Springfield



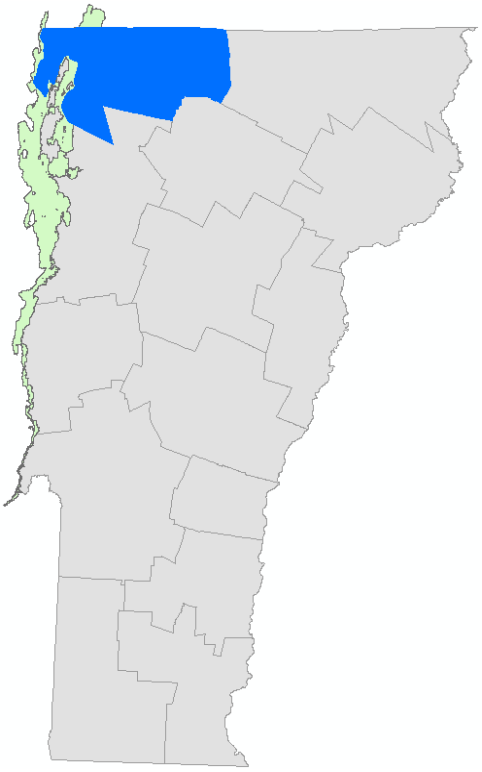
Inner ring is number of practices by type
Outer ring is CHT FTE by staff type

Medical Home Practices

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

St. Albans Health Service Area

Project Manager – Candace Collins, RN



At A Glance

13 practices recognized as Patient-Centered Medical Homes

36, 730 Vermonters seen by Blueprint practices in the past two years

7.8 FTE Community Health Team staff

4.3 FTE Spoke Staff

16 Community Self-Management Workshops offered

3.0 SASH Teams; 180 participants

2014 Highlights

MAT programs continues to expand:

- Number of prescribers increased from 6 to 11
- Number of clients in panel increased from 250 to 325
- 7 prescriber teams participating in the VT MAT Learning Collaborative → Using the Stability Index (Measure #1) as a basis to identify clients for referral to spoke care coordinators for care management or transitional care management

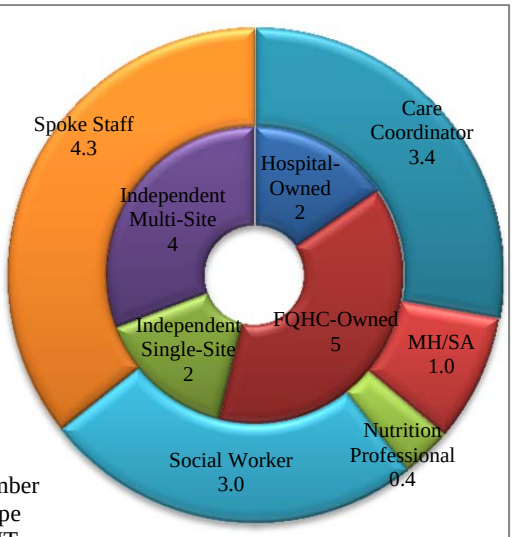
PCMH systematically identify complex and high risk patients for referral to CHT:

- 1,734 patients received support from the Core CHT team (4.5% of PCMH population)
- CHT services: Care management and coordination; health coaching; transitional care management; brief counseling; nutrition and diabetes education; coordination of benefits; panel management and referral to intensive case management programs

Medical Home Practices

Alburg Health Center
Cold Hollow Family Practice
Enosburg Health Center
Franklin County Pediatrics (closed 4/16/14)
Mousetrap Pediatrics – Enosburg
Mousetrap Pediatrics – Milton
Mousetrap Pediatrics – St. Albans
NMC Georgia Health Center
NMC Northwestern Primary Care
Richford Health Center
St. Albans Health Center
St. Albans Primary Care
Swanton Health Center
Max Bayard, MD

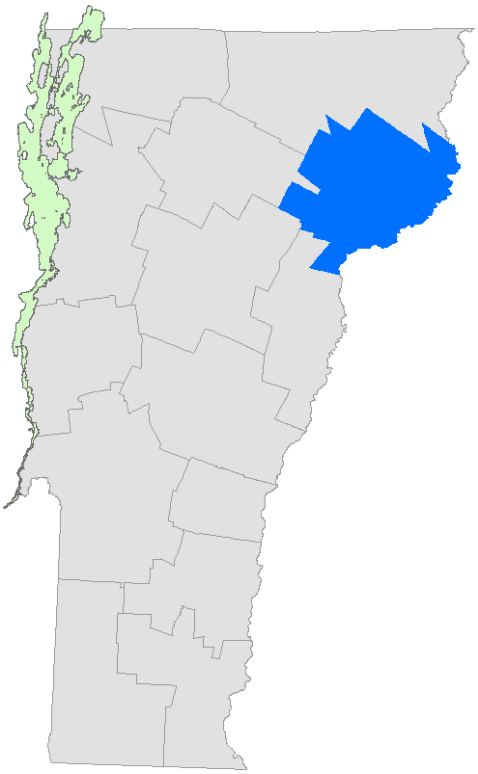
St. Albans



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

St. Johnsbury Health Service Area

Project Manager – Laural Ruggles, MBA, MHA



At A Glance:

6 practices recognized as Patient- Centered Medical Homes

23,563 Vermonters seen in Blueprint practices in the past two years

7.0 FTE Community Health Team Staff

2.0 FTE Spoke Staff

23 Community Self-Management Workshops offered

2.5 SASH Teams; 173 participants

2014 Highlights

Results of the CDC 30-month evaluation completed in February demonstrated that the CHT successfully bridges the gap between medical care and social needs of patients.

Partnered with SASH to offer Healthy Living Workshops to seniors

In May 2014, we partnered with Department of Corrections to offer two Healthy Living Workshops to people on probation. The workshops were well attended, and DOC staff report they have witnessed positive changes among participants.

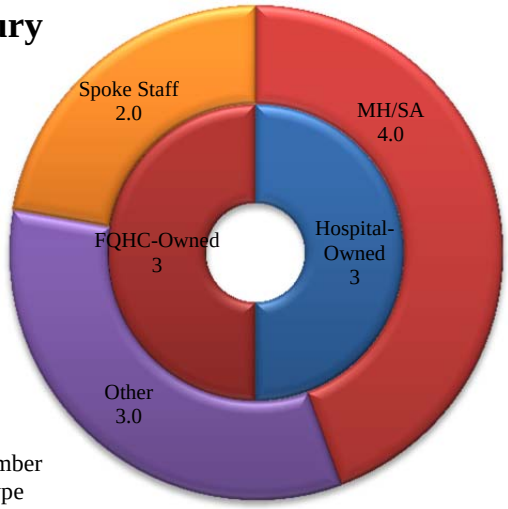
We participated in the VHCIP work groups and the GMCB's first payment reform pilot, the Vermont Oncology Project.

This holiday season the extended CHT partnered with the Department of Children and Families to donate gifts and wrapping paper for children in foster care to "shop" for gifts for their families and extended families.

Medical Home Practices

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

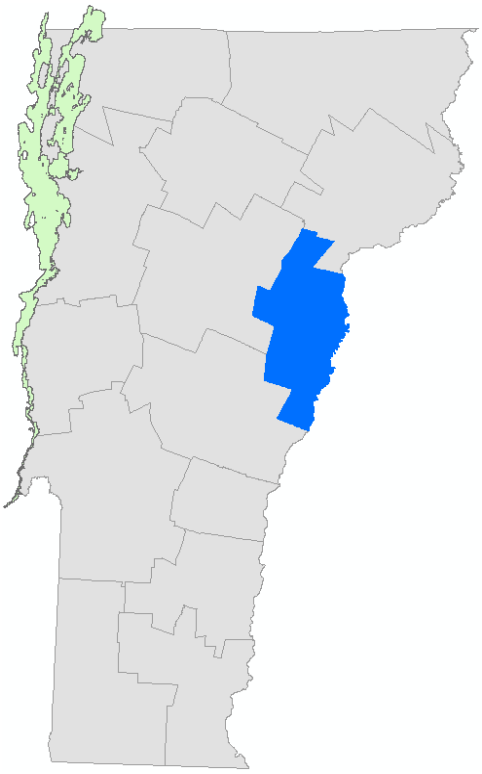
St. Johnsbury



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

Upper Valley Health Service Area

Project Manager – Donna Ransmeier



At A Glance

5 practices recognized as Patient-Centered Medical Homes

7,812 Vermonters seen by Blueprint practices in the past two years

0.8 FTE Community Health Team staff

3 Community Self-Management Workshops offered

1.0 SASH Team; 52 participants

2014 Highlights

Transitions of Care from inpatient hospitalizations and emergency department visits are being tracked for patients of all practices in the HSA. Care coordinators, nurses, and medical assistants ensure appropriate care by phone call and/or follow-up appointment scheduling within prescribed "best practice" and payer guidelines.

Since July 2014, when we instituted processes and tracking methods, 257 transitions of care have been documented with patients receiving more coordinated, integrated, and timely health care services.

All care coordinators are certified, or in the process of becoming certified, Tobacco Cessation Counselors.

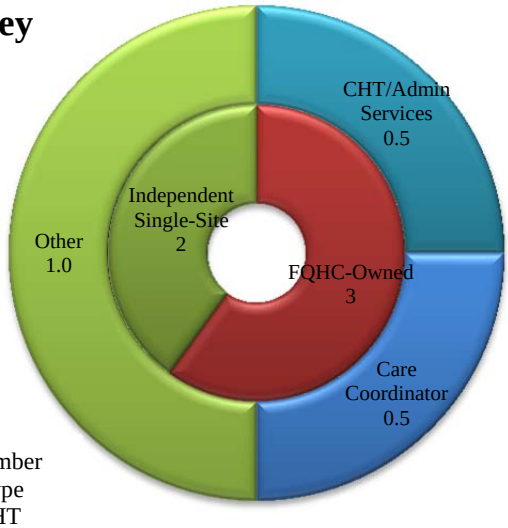
The Project Manager and one of the Care Coordinators are became Certified Healthier Living Workshop leaders/facilitators.

Medical Home Practices

Little Rivers Health Care
- Bradford Clinic
- East Corinth Clinic
- Wells River Clinic

Newbury Health Clinic
Upper Valley Pediatrics

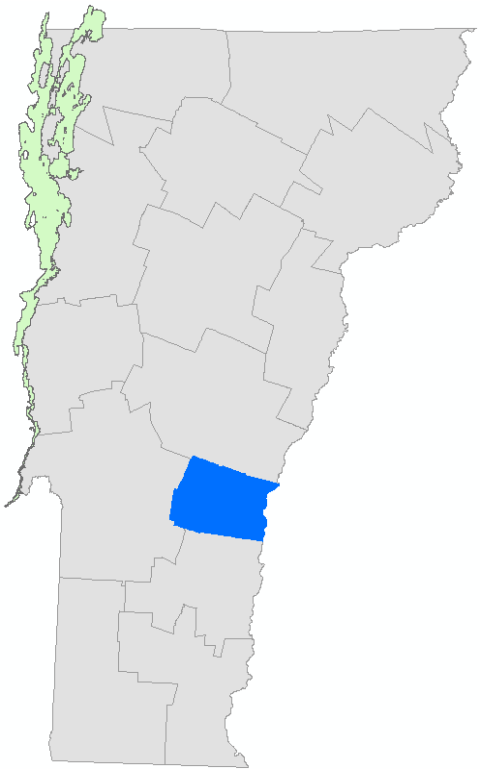
Upper Valley



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

Windsor Health Service Area

Project Manager – Jill Lord, RN



At A Glance

2 practices recognized as Patient-Centered Medical Homes

10,910 Vermonters seen by Blueprint practices in the past 2 years

8.2 FTE Community Health Team staff

2.0 FTE Spoke Staff

23 Community Self-Management Workshops offered

1.0 SASH Team; 111 participants

2014 Highlights

Established strong connections and working relationships between the Community Health Team and inpatient case management, the Emergency Department, Medication Assisted Therapy staff, and area Community Health and Human Service Agencies

Refined follow-up phone call system status post discharge from inpatient units and the Emergency Department

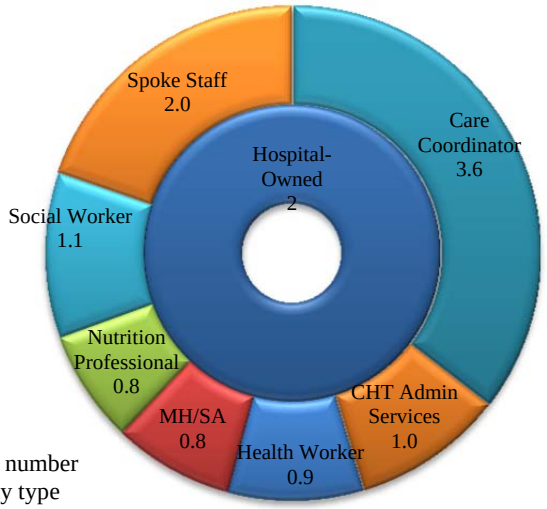
Organized a Volunteer Summit to maximize connections between the Community health Team and area volunteer agencies on behalf of the patients we serve

The Community Health Team served 747+ unique patients in 2014

Instituted quality improvement initiatives in self-management and interagency care management

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

Windsor



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

Medical Home Practices

Mt. Ascutney Hospital and Health Center
Ottauquechee Health Center

5. BLUEPRINT PROGRAMS AND SERVICES

5.a. Overview

In addition to the payment reforms discussed earlier (PMPM to providers for quality and the Capacity payment for Community Health Teams) the Blueprint program includes the following services and activities.

Patient-centered Medical Homes (PCMHs)
As of December 2014, 124 primary care practices are operating in Vermont as patient-centered medical homes (PCMHs). Each practice has achieved recognition by the National Committee for Quality Assurance (NCQA) as a patient-centered medical home that meets standards for high-quality, well-coordinated care.

These standards are based on peer-reviewed evidence supplemented by expert opinion and are updated regularly by the NCQA through a highly structured multi-stakeholder process. With each update, the standards become increasingly rigorous, promoting ongoing improvement in the way that primary care practices organize and coordinate care.

Multi-disciplinary Core Community Health Teams (CHTs)
Community health teams (CHTs) provide general and targeted populations with more direct and unhindered access to diverse staff, such as nurse care coordinators, social workers, counselors, dieticians, health educators, and others. These essential multi-disciplinary staff members augment and stimulate the provision of high-quality primary care as a coordinating feature in a community-oriented health system.

In combination, medical homes and community health team staff help link individuals more seamlessly with the services they need by strengthening network interactions with a larger array of medical and non-medical providers in their communities.

Evidence-based Self-management Programs
Intended to help Vermonters adopt healthier lifestyles and engage in preventive health services, the following group of self-management workshops are sponsored by the Blueprint and offered at the community level within each HSA:

- Stanford University Chronic Disease Self-management Program (Healthier Living Workshops for Chronic Disease)
- Stanford University Diabetes Self-management Program (Healthier Living Workshops for Diabetes)

- Stanford University Chronic Pain Self-management Program (Healthier Living Workshops for Chronic Pain)
- YMCA's Diabetes Prevention Program
- Tobacco Cessation (in collaboration with the Vermont Department of Health (VDH))
- Copeland Center Wellness Recovery Action Planning

Implementation of Health Information Technology (HIT)

The Blueprint and Vermont Information Technology Leaders (VITL) work collaboratively, providing connectivity from electronic health records (EHRs) to the Vermont Health Information Exchange (VHIE) and assisting Blueprint practices with improving the quality of data in their EHRs and the VHIE. The outcome is more accurate data in:

- EHRs used to produce lists (or reports) of patients that need attention, such as children who are overdue for immunizations or patients with one or more chronic diseases who have not been in for their regular exams or tests
- Clinical data registry used by the Blueprint to produce reliable outcome measurements and comparative effectiveness analyses
- VITLAccess used by clinicians at the point of care to view a patient's comprehensive clinical record, which helps enhance emergent care, care coordination, and transitions in care

Multi-Faceted Evaluation System

Blueprint accesses multiple sources of health data to evaluate the impact of the reforms and to provide actionable reports to organizations and communities across Vermont. Most notable, the data profiles, derived from Vermont's all-payer claims database, the Vermont Healthcare Claims Uniform Reporting and Evaluation System (VHCURES), clinical data from the statewide registry, and public health data sets, allow communities, organizations, and individual practices to assess their utilization rates, quality of care delivered, and population-based health metrics as compared to local peers and to the state as a whole, giving them data to assist in honing their quality improvement efforts.

Learning Health System

In each community, project managers have organized workgroups focused on coordination of health and human services with the goals of maximizing available resources to improve outcomes. In conjunction with these efforts, practice facilitators provide guidance and support that helps practices and community health teams plan and implement PCMH operations and continue ongoing quality improvement and innovation. Statewide facilitators, project managers, CHT members, and practices share learning across the system through a series of networking meetings and quality improvement learning collaboratives.

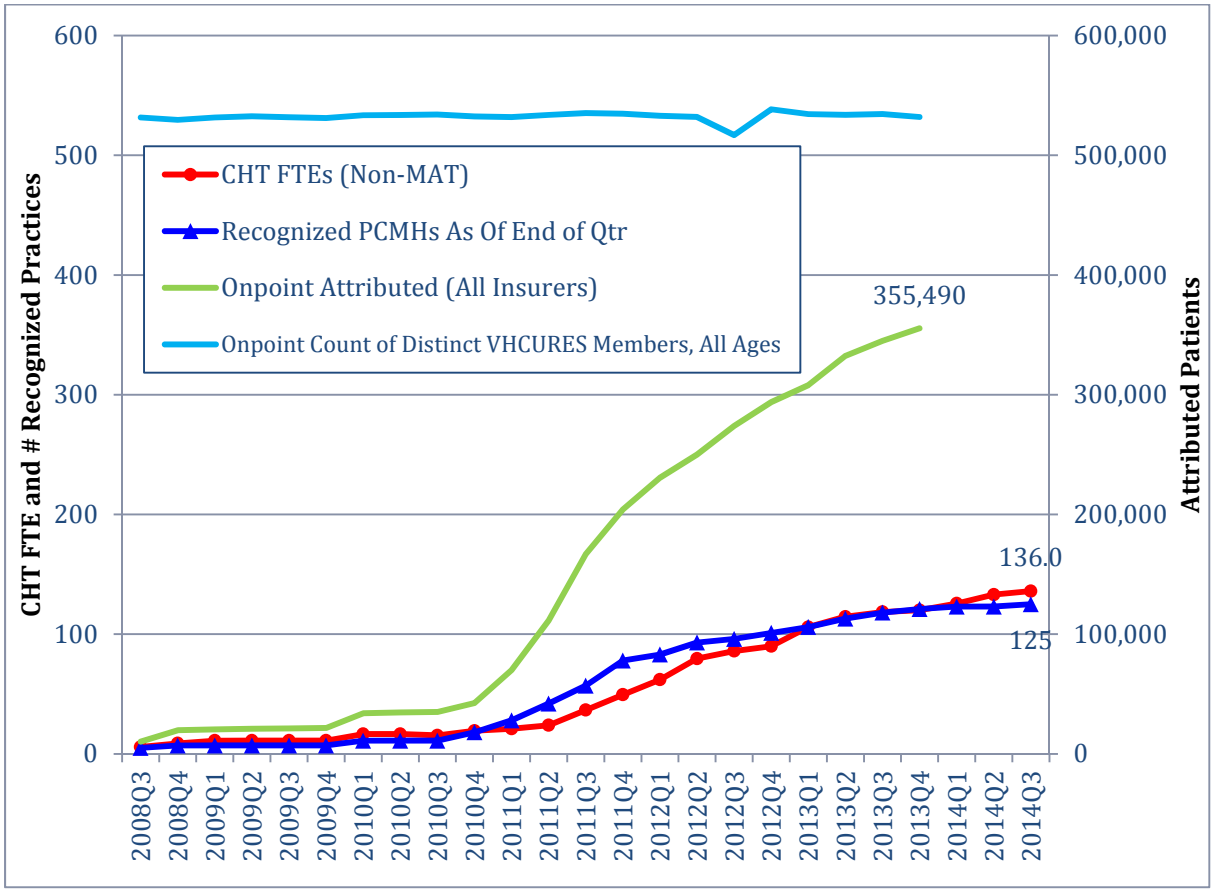
5.b. Recognized Practices and Patient Populations Served

Starting in 2011 and continuing through 2014, the number of primary care practices engaged in patient-centered medical home (PCMH) activities grew steadily. Having completed the progression from pilot to program phase as of 2013, the Blueprint now has a solid presence in all 14 Health Service Areas (HSAs).

As of December 2014, 124 primary care (including naturopathic, new in 2013) practices have successfully undergone the national recognition process and participate in the Blueprint. These practices collectively provided the majority of primary care for 347,489 unique Vermont residents. In 2014, 56 practices continued their commitment by renewing their NCQA recognition, with 50 practices updating from the 2008 NCQA-PCMH standards to the more rigorous 2011 NCQA-PCMH standards, 4 being scored a second time on the 2011 standards, and 2 moving from the 2008 standards to the new 2014 standards, on which all Blueprint practices will be scored beginning in March 2015.

Figure 8 highlights the growth in NCQA-PCMH recognized practices in Vermont since July 2011.

Figure 8. NCQA-PCMH Recognized Practices & Patients Served July 2011-December 2014



**The trend for the number of recognized practices reflects a combination of market saturation by the Blueprint and mergers/consolidation of practices.*

The participating practices are affiliated with a wide range of organization types, as summarized below in Table 6.

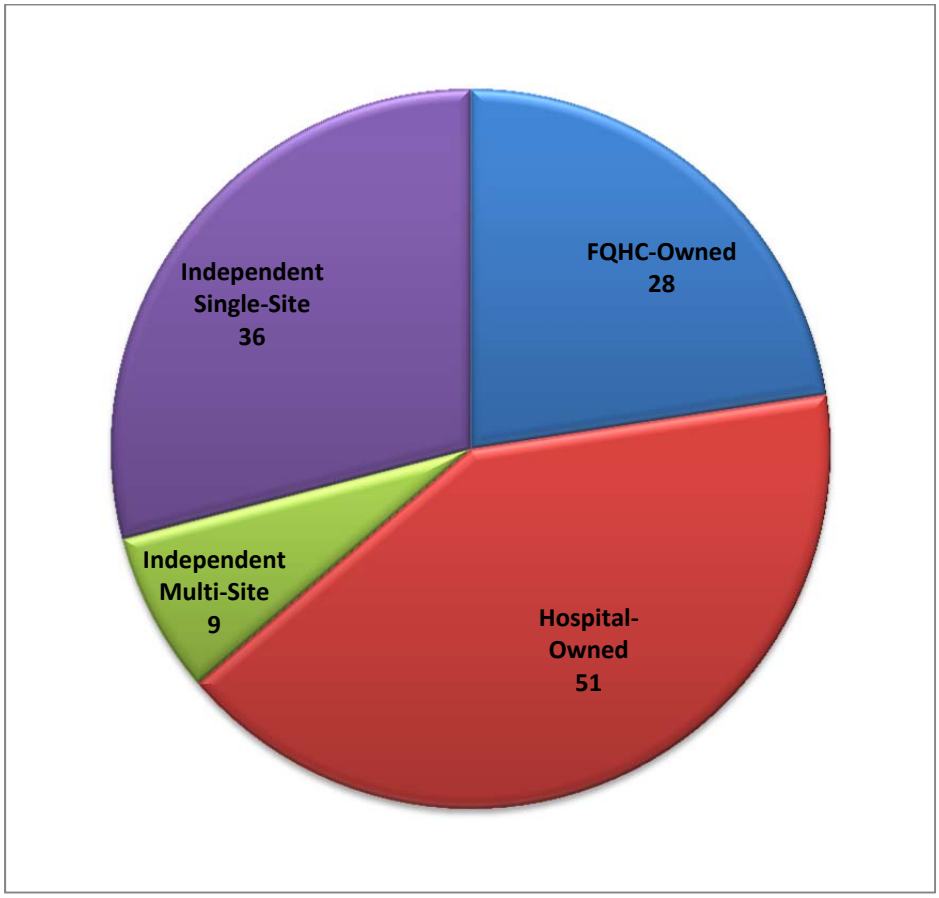
Table 6. Recognized Practices and their Organizational Affiliations – December 2014

	Practices	PCP Clinicians	PCP Clinician Full Time Equivalents (FTEs)
Hospital Owned Practices	51	331	232
Independent Single Site Practices	36	141	102
Independent Multi Site Practices	9	44	35
Federally Qualified Health Centers	28	166	127
Total	124	682	496

In 2013, the first naturopathic physicians were recognized and supported by the Blueprint with two (2) additional naturopathic practices joining the Blueprint in 2014.

In 2014, six (6) new practices joined the Blueprint, scoring on the NCQA-PCMH 2011 standards for the first time. In addition, all participating Blueprint primary care providers are re-evaluated using updated NCQA standards every three years. Figure 9 shows the affiliation breakdown of PCMH practices participating in the Blueprint.

Figure 9. Number of Active Blueprint Practices by Type/Affiliation



5.c. Community Health Teams

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

These local multi-disciplinary teams are designed and hired at the community (HSA) level. Local leadership convenes a planning group to determine the most appropriate use of these positions, which can vary depending upon the demographics of the community, identified gaps in available services, and strengths of local partners.

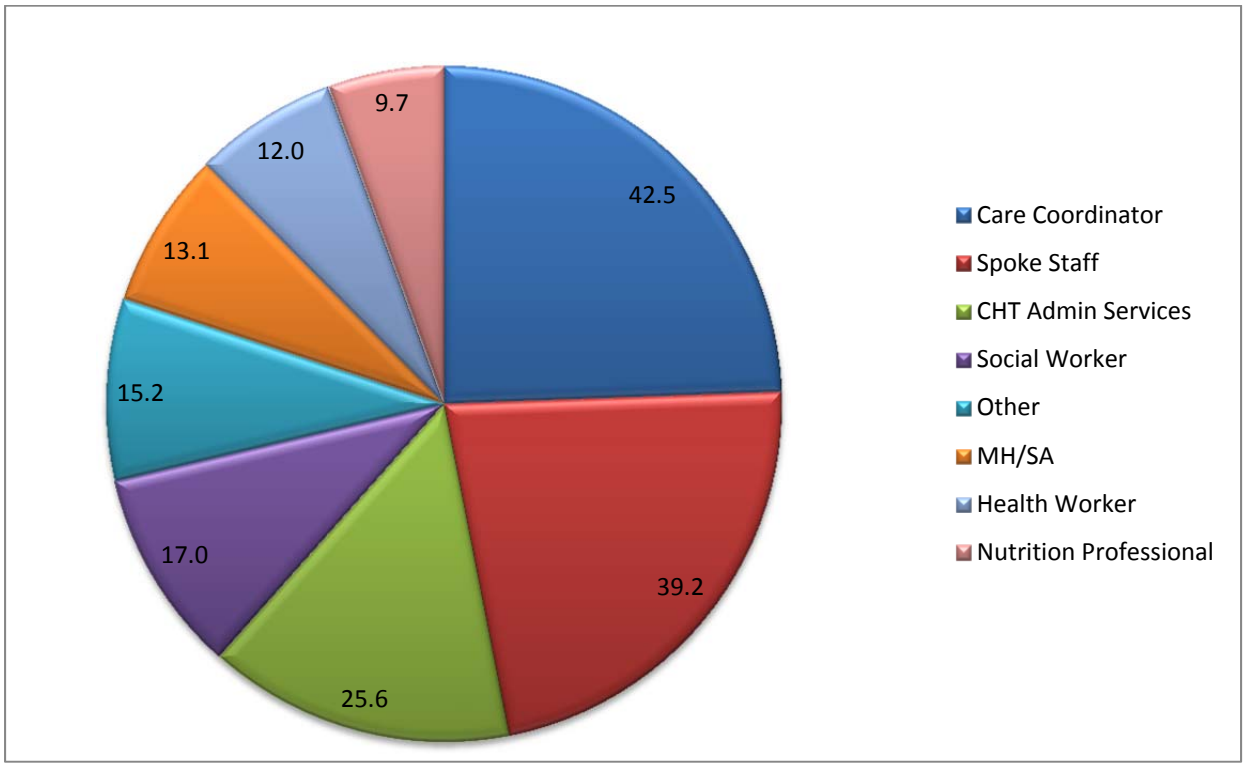
CHT job titles include, but are not limited to:

- Care Coordinator
- Case Manager
- Certified Diabetic Educator

- Community Health Worker
- Health Educator
- Mental Health Clinician
- Substance Abuse Treatment Clinician
- Nutrition Specialist
- Social Worker
- CHT Manager
- CHT Administrator

The general job categories of CHT team members are illustrated in Figure 10, and the specific CHT roles in each HSA can be found in the Individual Health Service Area (HSA) Snapshots section of this document starting on page 36.

Figure 10. CHT Staff FTEs by Job Category Statewide – All Funding Sources



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

Importantly, CHT services are available to all patients in the primary care practices they support, regardless of whether these patients have health insurance of any kind or are uninsured.

The funding available to support the local CHT is proportional to the population served by the recognized and engaged primary care practices in the HSA. Currently, this level is set at $350,000 per year for a general population of 20,000 served by the practices ($17,500 per year for every 1000 patients).

As new practices join the Blueprint, the CHT staffing and funding is increased in proportion to the patients seen by the practices. Figure 11 shows the growth of CHT staffing, consistent with the statewide implementation of the Blueprint for Health.

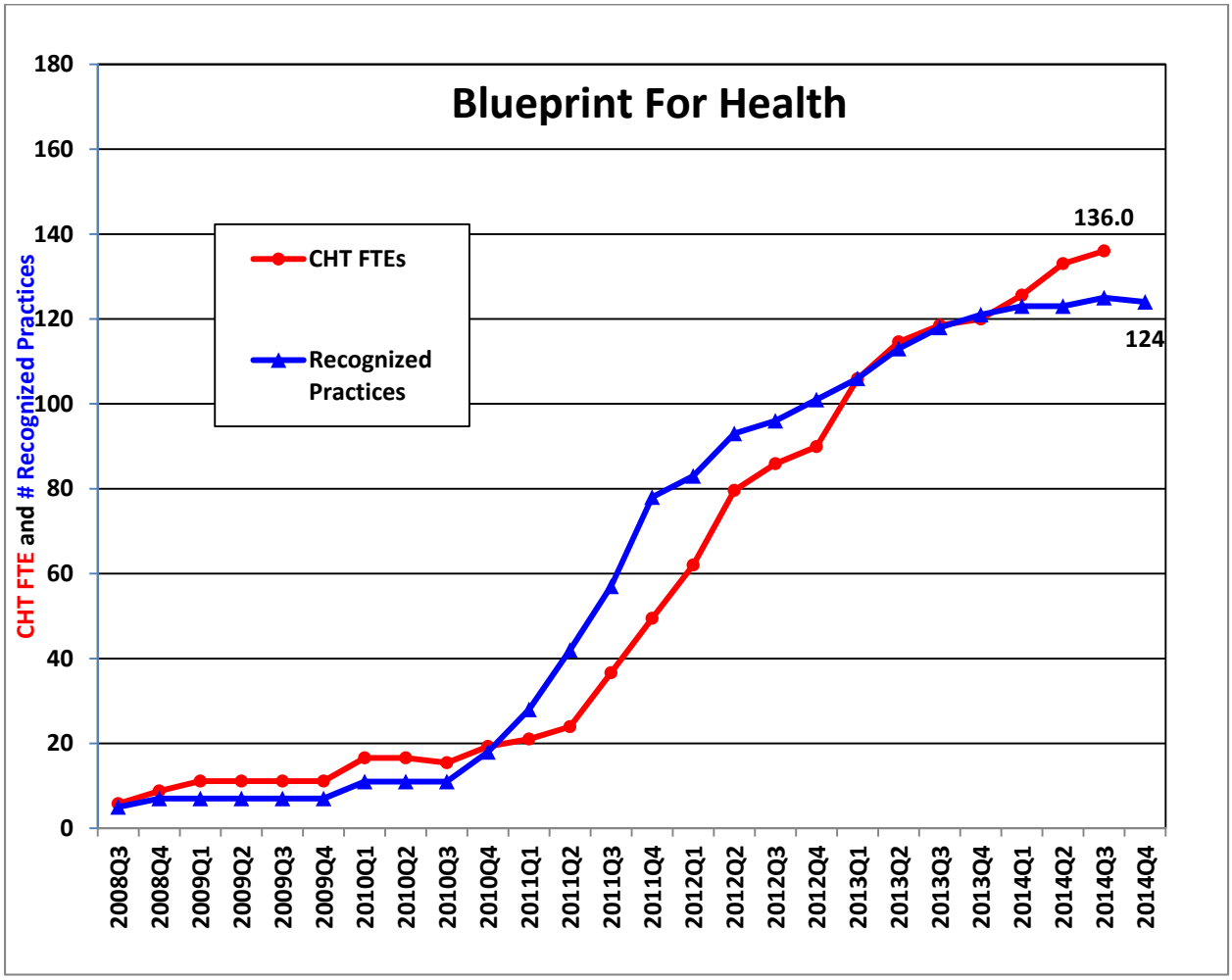
Blueprint Story – Diabetes Supports

Early in 2014, the CHT in one of the more rural HSAs began working with Ruth (not her real name), a diabetic patient with an HbA1c of 8.8. Ruth also had a history of depression, agoraphobia, hypertension, and little physical activity. As a result, she was referred to a pilot study for diabetes management, conducted by the CHT in collaboration with the Home Health Agency.

Through this program, Ruth received care coordination from CHT staff, including a home monitoring device, dedicated weekly home visits from a registered nurse, and regularly scheduled diabetes education visits.

In April 2014, Ruth's HbA1c had dropped to 7.2, and in October 2014, it lowered to 6.6. Due to the CHT and Home Health supports she received, Ruth has been able to decrease her diabetes management and hypertension medications, has lost weight, has brought her blood pressure under control, and has increased her physical activity. Needless to say, Ruth is happier and healthier, her primary care provider is proud of her results, and the CHT staff feels great about her success and the success of the pilot program!

Figure 11. NCQA-Recognized Practices & CHT Staffing: July 2008 - December 2014



5.d. Extended CHT

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

Hub & Spoke: Builds on the local Blueprint infrastructure to hire and deploy nurses (1.0 FTE) and licensed addictions treatment counselors (1.0 FTE) for panels of 100 patients being treated with Medication Assisted Therapy (MAT) for opioid addiction in office-based medical practices ("Spokes"). This program also augments staffing in outpatient addiction treatment centers ("Hubs").

SASH: Provides nurse (0.25 FTE) and care coordination and health promotion (1.0 FTE) support to panels of 100 Medicare beneficiaries.

VCCI: Supports the top 5% high-utilizing Medicaid beneficiaries through a statewide team of licensed case managers/care coordinators (nurses, LADCs and/or LICSWs) for time-limited periods based on the patient's engagement and making progress towards identified goals.

Table 7 shows the community staffing for health and human services care directly resulting from the Blueprint for Health.

Table 7. Blueprint Staffing for Community Health and Human Services

Key Components	December 2014
PCMHs (scored by UVM)	124
PCPs (unique providers)	682
CHT FTEs (core staff)	135
SASH provider FTEs (extenders)	65
Spoke Staff FTEs (extenders)	39

5.d.1. Support and Services at Home (SASH)

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

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.

CMMI based this extension on promising evaluation results showing a reduced the rate of growth in total Medicare expenditures and expenditures for post-acute care among SASH participants involved in the program for at least one year. Most importantly, the evaluation noted the key qualitative finding that SASH successfully integrates services across community-based organizations and links care teams to primary care practices, hospitals, and CHTs.

Administered through Cathedral Square and five Designated Regional Housing Organizations (DRHOs), SASH brings a caring partnership together to support aging at home. The "SASH teams", comprised of staffing from SASH and primary partners including Home Health Agencies, Area Agencies on Aging, and Community Mental Health Organizations, support panels of participants throughout the state. This SASH partnership connects the health and long-

term care systems to and 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.

SASH provides an organized, person-centered presence in the community with a SASH Coordinator and Wellness Nurse serving a panel of 100 participants. Since by design the program serves all Medicare beneficiaries as needed, SASH participants may live either in subsidized housing or in residences in the community at large. SASH team members focus their efforts around three 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

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

The team meets regularly to facilitate a comprehensive approach to care management that focuses both on the needs of each individual and the health of the population managed as a whole. Individual Healthy Living Plans are developed for each participant, and the SASH team then provides the tools necessary to help each participant meet those goals. Based on the cumulative and common goals identified, a Community Healthy Living Plan is created. This population-level plan addresses specific interventions from a directory of evidence-based programs organized around the following five key areas:

1. Falls
2. Medication management
3. Control of chronic conditions
4. Lifestyle barriers
5. Cognitive and mental health issues

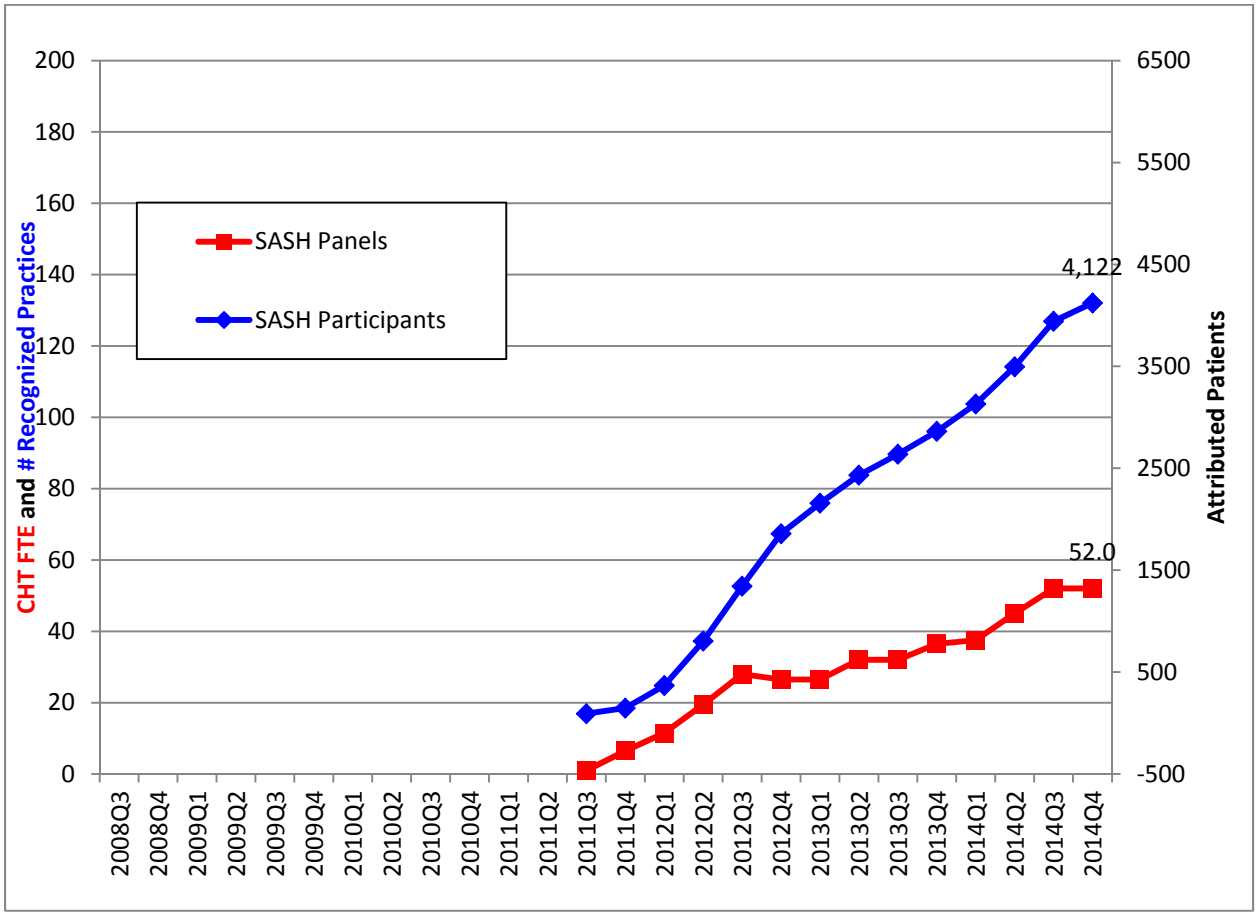
Starting as a single pilot team in Burlington in 2009, SASH grew to 26.5 teams by the end of 2012, added 10 new teams in 2013, and added another 15.5 teams in 2014. With 52.0 teams in place, the total number of people served by SASH grew from 2,862 participants at the end of 2013 to 4,122 participants at the end of 2014 – an annual increase of 44%.

SASH teams are now in place in every county and HSA in Vermont. Although initially piloted in congregate housing sites, the statewide implementation of SASH includes 478 community participants who live in single family homes or apartments.

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

Refer to Figure 12 for a growth timeline of the SASH program across Vermont.

Figure 12. SASH Implementation July 2011 through December 2014



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

Refer to Figure 13 for a map of the Blueprint Health Service Areas (HSAs) and to Table 8 for breakouts of the SASH implementation by HSA.

Figure 13. Blueprint Health Service Areas

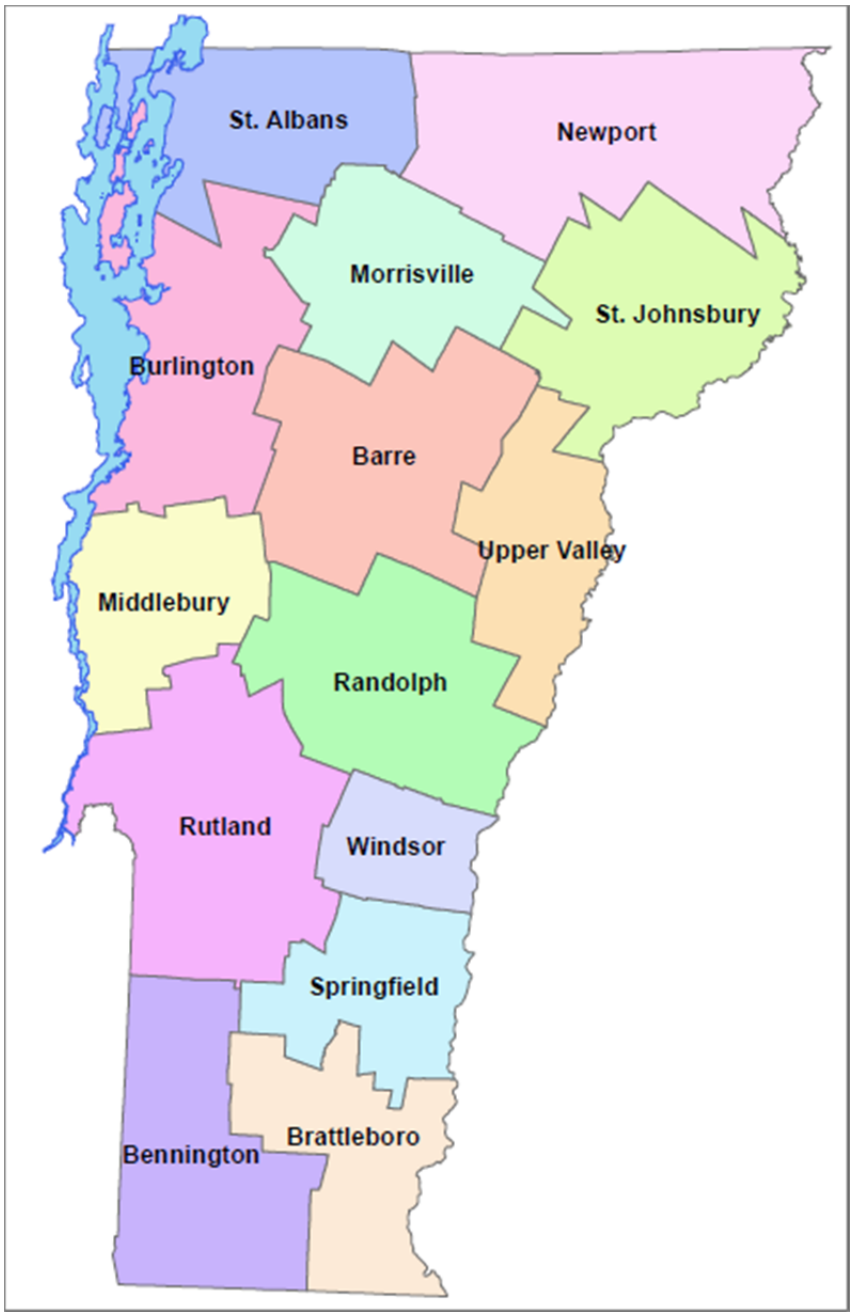


Table 8. SASH Implementation by Health Service Area (HSA) - 2014

HSA	Blueprint Practices	SASH Teams (Panels)	SASH Participants	Panel Capacity
Barre	12	5.5	395	550
Bennington	10	3.0	247	300
Brattleboro	9	3.0	215	300
Burlington	27	17.0	1,614	1,700
Middlebury	9	3.5	204	350
Morrisville	6	1.0	87	100
Newport	6	3.5	211	350
Randolph	7	2.0	90	200
Rutland	7	5.0	427	500
Springfield	5	1.0	116	100
St. Albans	13	3.0	180	300
St. Johnsbury	6	2.5	173	250
Upper Valley	5	1.0	52	100
Windsor	2	1.0	111	100
Total	**124**	**52.0**	**4,122**	**5,200**

5.d.2. The Care Alliance for Opioid Treatment (Hub & Spoke Program)

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

There is clear evidence of a high level of effectiveness for medication assisted treatment (MAT) with either methadone or buprenorphine. Medication assisted treatment outcomes include:

- Abstention from or reduced use of illicit opiates
- Reduction in non-opioid illicit drug use, such as cocaine
- Decreased criminal behavior
- Decreased risk behavior linked to HIV and hepatitis C

Three partnering entities - the Blueprint for Health, the Department of Vermont Health Access (DVHA), and the Vermont Department of Health (VDH) Division of Alcohol and Drug Abuse Programs (ADAP) - in collaboration with local health, addictions, and mental health providers are implementing a statewide treatment program. Grounded in the principles of Medication

Assisted Treatment[7], the Blueprint's health care reform framework, and the Health Home concept in the Federal Affordable Care Act, the partners have created the Care Alliance for Opioid Treatment, known as the Hub & Spoke initiative. This initiative:

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

- *Enhances Methadone treatment programs (Hubs)* by augmenting the programming to include Health Home Services to link with the primary care and community services, provide buprenorphine for clinically complex patients, and provide consultation support to primary care and specialists prescribing buprenorphine

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

Under the Hub & Spoke approach, each patient undergoing MAT will have an established medical home, a single MAT prescriber, a pharmacy home, access to existing Blueprint CHTs, access to Hub or Spoke nurses and clinicians, and access to VCCI services as appropriate. The most common Spoke practice settings are:

- Primary care
- Obstetrics and gynecology
- Psychiatry
- Practices specializing in the management of chronic pain

As part of the Blueprint for Health Community Health Teams (CHTs), a Registered Nurse and a Licensed Counselor are hired for every 100 Medicaid beneficiaries who are prescribed buprenorphine for opioid addiction. Medicaid supports this Spoke staff through the local Blueprint infrastructure as a capacity-based payment, thus eliminating the need for fee-for-

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

service billing and patient co-pays, which often are barriers to services for patients with addiction and mental health conditions.

Embedding the staff directly in the prescribing practices allows for more direct access to mental health and addiction services, promotes continuity of care, and supports the provision of multidisciplinary team care. Like the Blueprint CHTs, Spoke staff (a nurse and clinician case manager) are provided free of cost to patients receiving MAT, essentially as a "utility" to the practices and patients.

Building on the concept first introduced by Vermont physician John Brooklyn, MD, the "Hub & Spoke" is characterized by a limited number of specialized, regional addictions treatment centers working in meaningful clinical collaboration with general medical practices. Specializing in the treatment of complex addiction, the regional centers (Hubs) would provide intensive treatment to patients and consultation support to medical providers (Spokes) treating patients in the general practice community. This framework efficiently deploys addictions expertise and helps expand access to care for Vermonters (Figure 14).

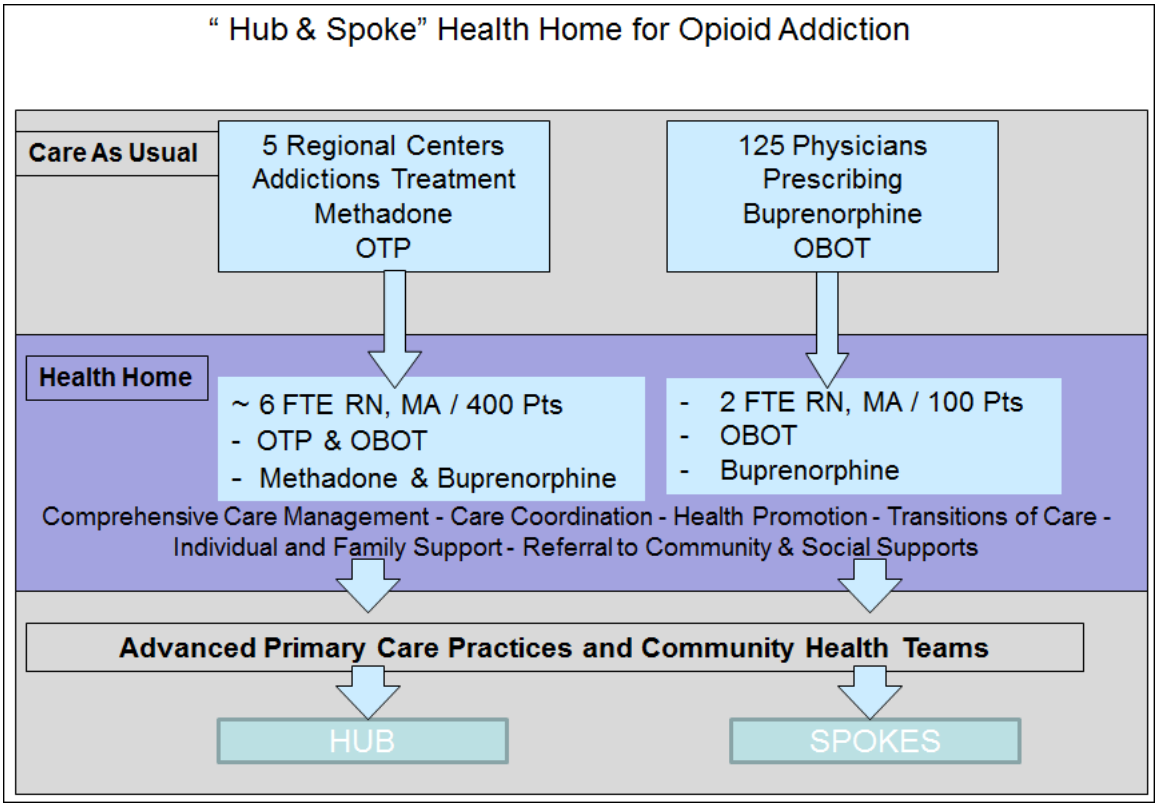
Blueprint Story – Addictions Treatment

John (not his real name) developed heart problems in his forties, and stents were put in his heart in 2011. Prescribed oxycodone for pain after his surgery, when it ran out, John started searching for oxycodone due to the energy it gave him to "work like a 20-year-old." Over the next three years, John developed a daily habit of 175 mg of oxycodone, reinforced by withdrawal symptoms that included shaking legs, vomiting reddish bile, impaired concentration to the point of running into walls, irritability, and tearfulness. He became isolated from family and began using heroin.

At the point when John started thinking about death as an escape from the cycle of addiction, he called a buprenorphine provider and completed an initial assessment with Spoke staff. John immersed himself in groups led by Spoke staff and has not used for close to six months. His first challenge was an acute injury two months after beginning treatment for which he was prescribed pain medication. John asked his addiction provider to help him manage this medication, and he only took it as prescribed.

As a result of his addictions treatment, John reports vastly improved relationships with family members and tremendous satisfaction in enjoying the natural world and the stability of his current life. He attributes these changes as much to his relationships with his provider and Spoke staff and contact with others in recovery as to his medication assisted treatment.

Figure 14. "Hub & Spoke" Health Home for Opiate Dependence



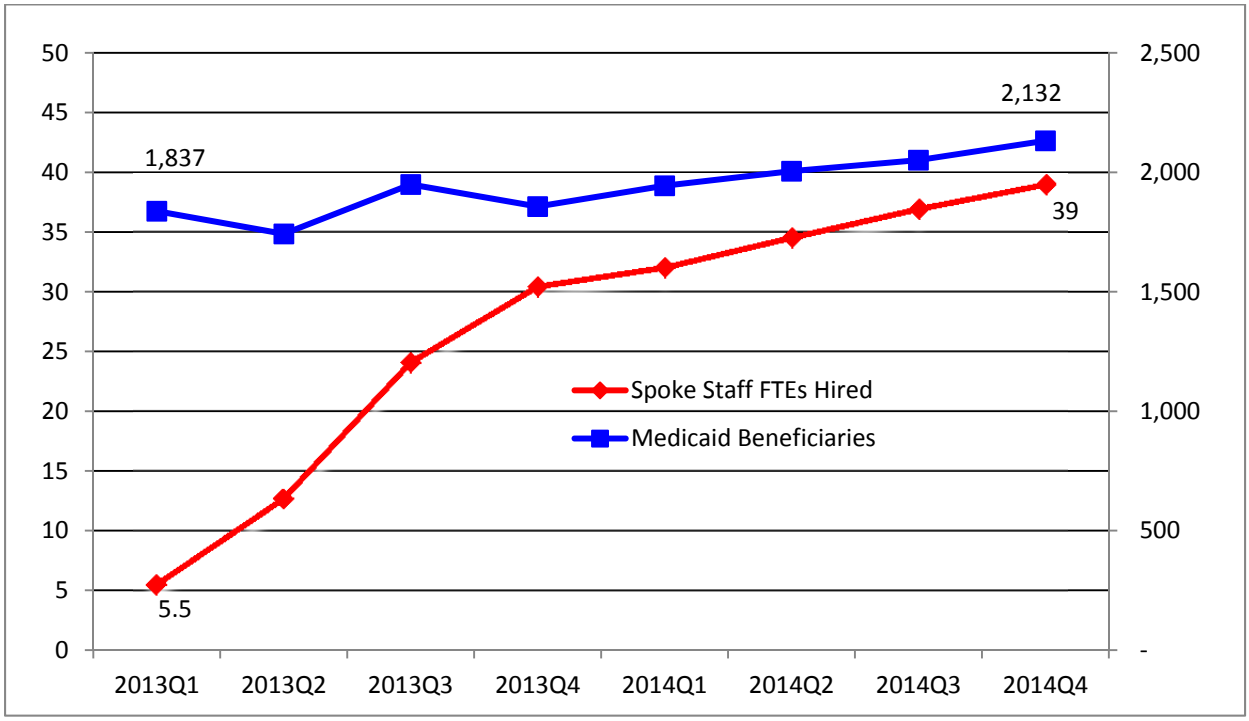
In March 2014, The Centers for Medicare and Medicaid Services (CMS) officially approved two Health Home State Plan Amendments (SPAs) for Vermont, one beginning July 2013 and the second beginning January 2014. The SPAs make Medicaid beneficiaries with opioid addiction eligible for enhanced services, including care coordination, health promotion, transitions of care, and community support.

The Hub & Spoke innovation is in the coordinated, reciprocal clinical relations between the specialty addictions centers and the general medical practices. The framework facilitates the development of a treatment continuum that spans the federal regulatory framework for medication assisted treatment and supports the dissemination of addictions treatment capacity in the larger health system. Success in this framework depends on the capacity at both the Hubs and Spokes to make and receive referrals. It also requires a funding mechanism that supports the clinical care management activities that comprehensive and coordinated care for chronic conditions requires.

The Care Alliance for Opioid Treatment[8] (Hub & Spoke) was implemented statewide in 2013 and 2014. The Methadone treatment programs began offering Health Home Services and started dispensing buprenorphine to patients with complex needs. A new Hub program opened in the Rutland area in November 2013. "Spoke" staff (nurses and licensed counselors) have been recruited and deployed statewide to all willing physician practices that prescribe buprenorphine. To date, 39 full-time equivalent nurses and addictions counselors have been hired and deployed to over 60 different practices.

Figure 15 shows the implementation of Spoke staffing and Medicaid beneficiaries from January 2013 through December 2014.

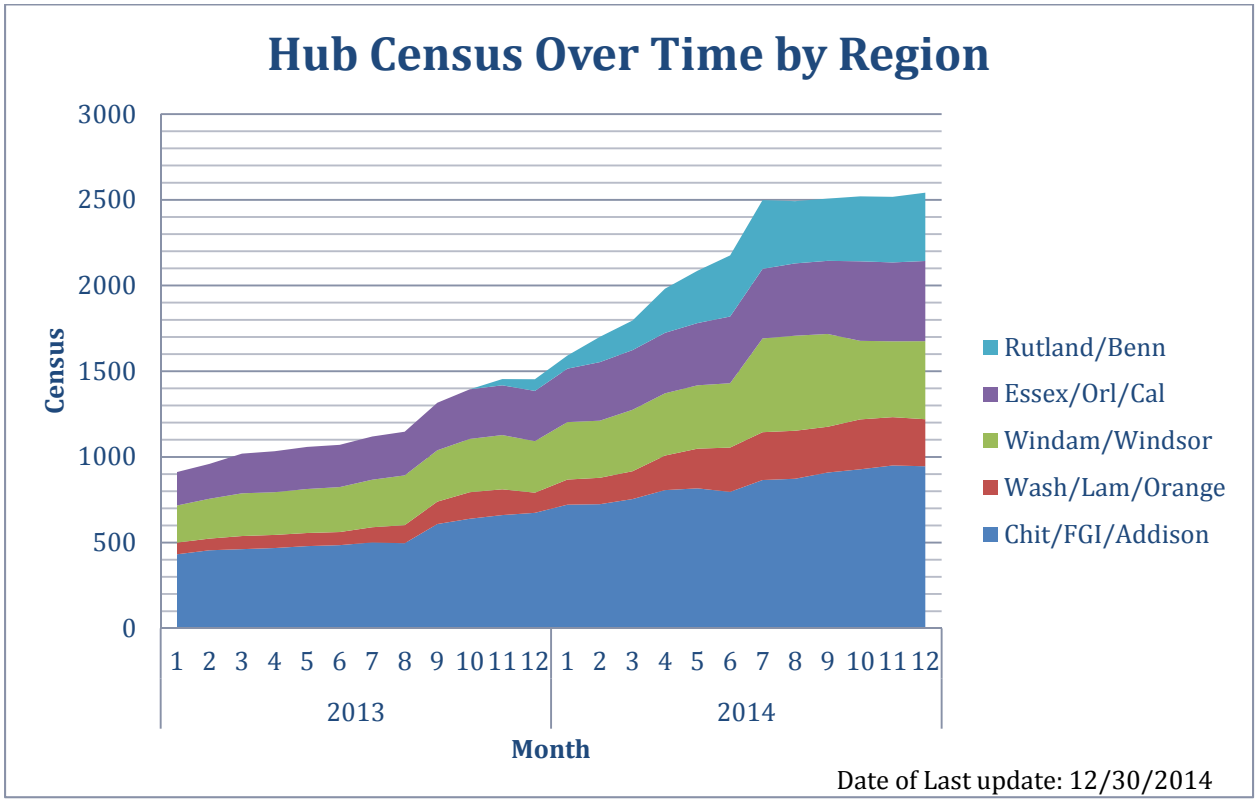
Figure 15. Spoke Staffing and Medicaid Beneficiaries: January 2013 – December 2014



The Hub programs expanded caseloads and this is dramatically improving access to intensive treatment of opioid addiction (Figure 16).

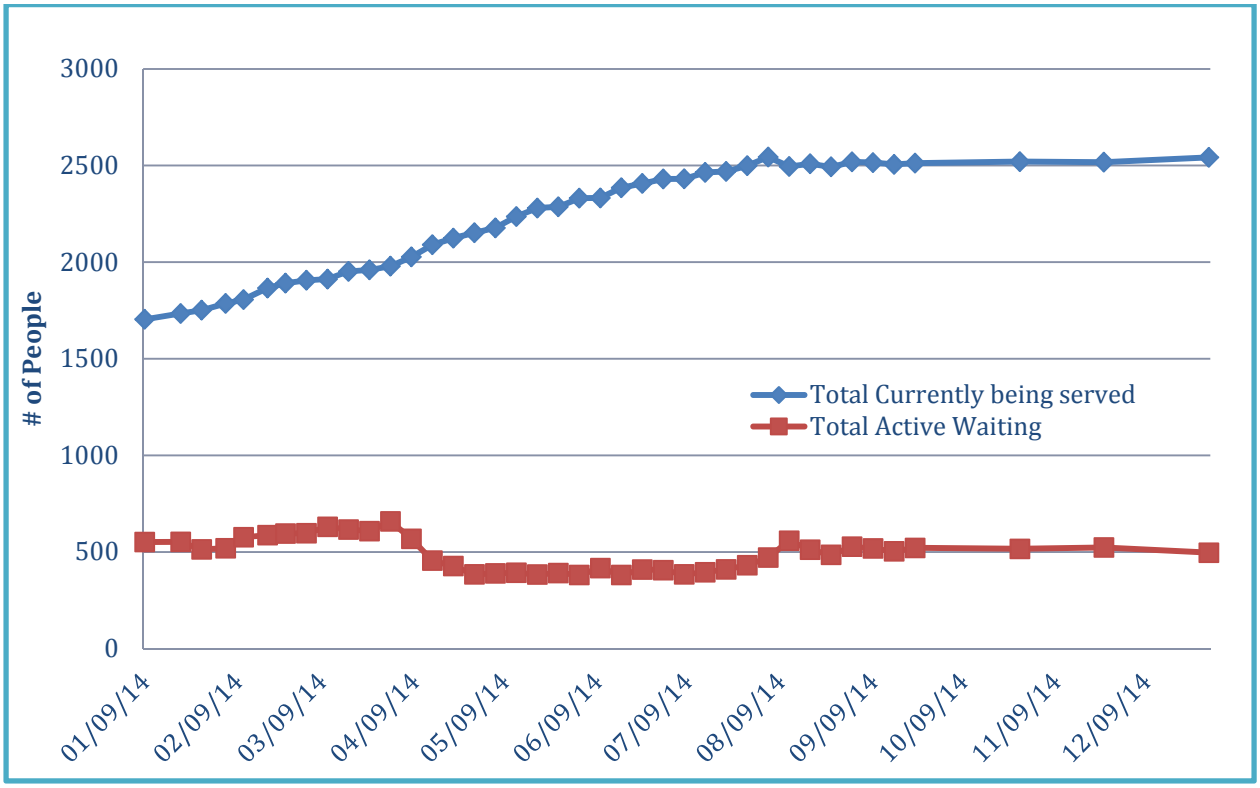
[8] http://healthvermont.gov/adap/treatment/documents/CareAllianceOpioidAddiction.pdf

Figure 16. Hub Census by Region



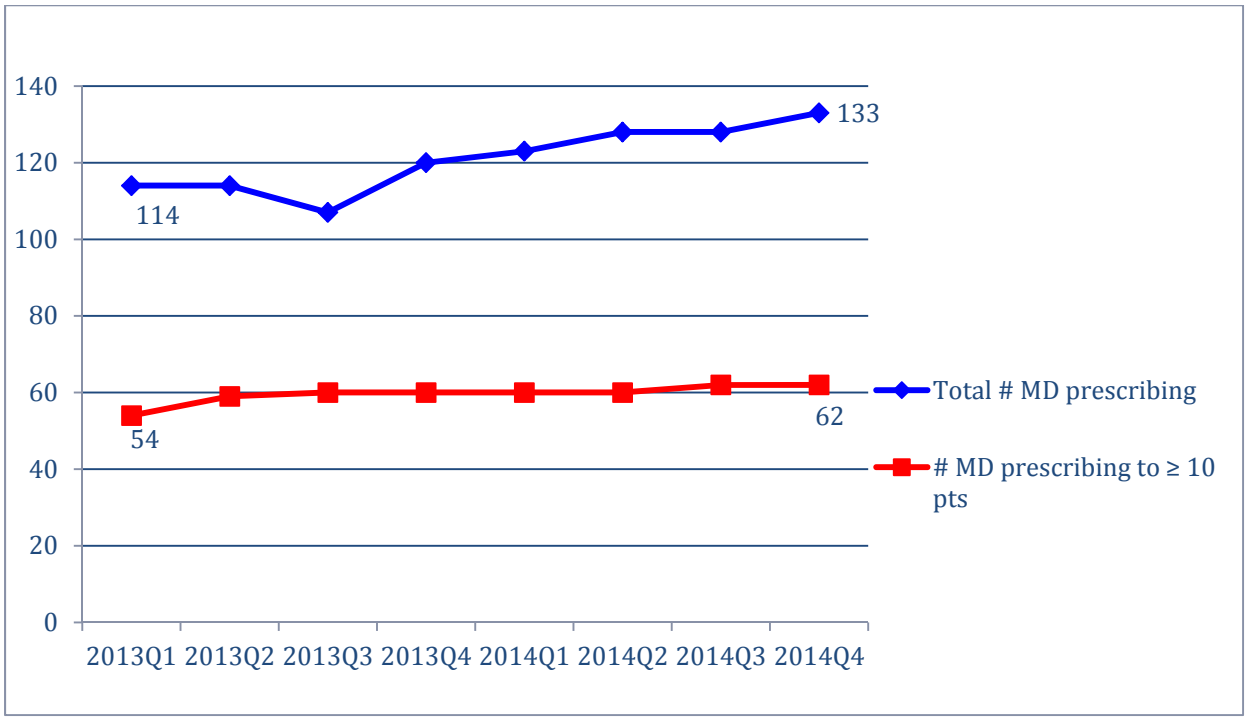
Even as the Hub caseloads have tripled, the number of Vermonters on waiting lists for treatment remained relatively stable at approximately 500 state-wide (Figure 17).

Figure 17. Hub Patients and Waiting List Over Time



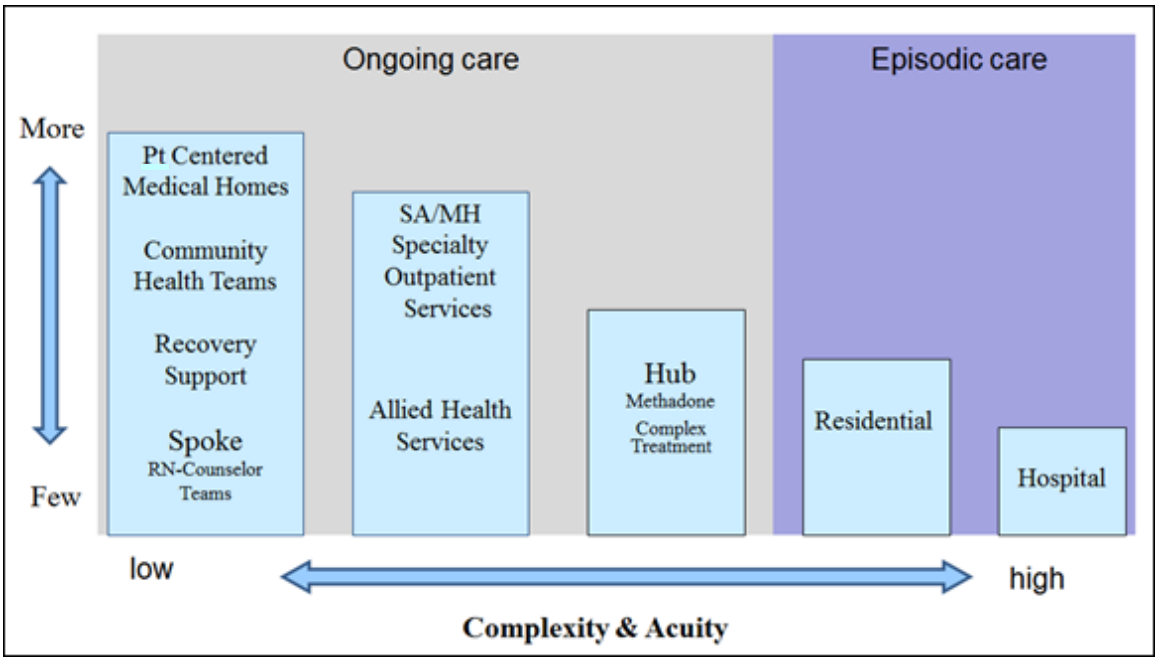
The large waitlists for Hub treatment and the relatively modest increase in Medicaid beneficiaries served in Spokes indicates a continued need to expand access, especially to Spokes. By federal regulation, an MD may prescribe buprenorphine to up to 100 patients at a time. Expanding access requires engaging new providers and increasing the caseloads of current providers. Although the most recent months show positives trends, the number of providers and their caseloads has yet to significantly improve (see Figure 18).

Figure 18. Number of Physicians Prescribing Buprenorphine & Physicians Seeing 10 or More Patients



The Hub & Spoke is part of Vermont's larger addictions, mental health, and human services continuum of care as pictured in Figure 19.

Figure 19. Continuum of Health Services – Addictions Treatment



For detailed supporting documents about the Hub & Spoke planning and implementation, refer to http://hcr.vermont.gov/blueprint.

5.d.3. Vermont Chronic Care Initiative (VCCI)

The Vermont Chronic Care Initiative (VCCI) is a statewide Medicaid program that provides care coordination and intensive case management services to non-dually-eligible Medicaid members diagnosed with one or more chronic health conditions. VCCI primarily focuses on improving outcomes and reducing unnecessary utilization.

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 based primarily, though not solely, on the following criteria:

- Top 5% of Medicaid cost/utilization
- High emergency department and hospital utilization
- Multiple prescribed medications (poly pharmacy)
- One or more chronic health conditions
- Co-occurring conditions of substance abuse or mental health

- Not receiving other CMS-funded case management services, such as Choices for CARE, PACE, CRT, and so on
- Not dually eligible for Medicare

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

- Chronic Disability and Payment System (CDPS) score
- Actual per-member-per-month cost to the Medicaid program
- Number of chronic conditions
- Number of emergency department and inpatient encounters
- 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
- Emergency department staff
- Field and embedded program staff
- Other internal and external statewide partners, including Blueprint CHT staff who partner with VCCI at the local level for direct referrals and transitions of care support between levels of service for the Medicaid population

Department of Vermont Health Access (DVHA) analysis of Medicaid claims, indicates that VCCI demonstrated net savings[9] over anticipated costs of $23.5 million in state fiscal year 2013 (July 1, 2012 through June 30, 2013) (Table 9).

[9] The relative contribution of VCCI to the savings shown in the Blueprint study group in the Program Outcomes section of this report cannot be quantified until successful completion of an analytics project on this segment of the Medicaid population.

Table 9. Rate Reductions in Inpatient Admissions, 30-day Readmissions, and Emergency Department Visits Realized for VCCI-targeted Medicaid Population

VCCI Top 5% Population			
	ACS IP Admissions	**30-Day readmissions**	**ED Visits**
SFY 12 Rate	476/1,000	77/1,000	1,461/1,000
SFY 13 Rate	301/1,000	51/1,000	1,215/1,000
% Change SFY12 to SFY13	-37%	-34%	-17%

**Net Savings in state fiscal year (SFY) 2013 over anticipated = $23.5 million*

Since most providers are currently reimbursed by the state's Medicaid program through a fee-for-service model, reductions in unnecessary spending achieved by VCCI translate directly to savings for the state's Medicaid program budget.

VCCI reaches Medicaid members primarily through a team of licensed case managers/care coordinators (nurses, LADCs and/or LICSWs) operating at the local level. VCCI staff serves members in a variety of settings, including as embedded resources within provider practices and hospitals with a high volume of Medicaid members. Embedding staff facilitates:

- Direct communication, care coordination, and referrals
- 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%.

Employed by DVHA, VCCI case managers/care coordinators 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 Service Division/eligibility staff, Department of Corrections (DOC) probation and parole colleagues, and VDH/local health office leadership and staff.

5.e. The Stories of How the Delivery System is Changing

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

5.f. Self-Management Support Programs

5.f.1. Introduction

The Blueprint offers a continuum of services to engage patients in improving and maintaining their own health. Services range from individualized self-management support in primary care practices and via CHTs to community-based self-management workshops. Regardless of the setting or program, the same techniques are introduced and reinforced, including patient engagement in goal setting, establishing action plans, and problem solving.

5.f.2. Community Based Self-management Programs

Starting in 2005, the Stanford Chronic Disease Self-Management Program (CDSMP) was introduced in Vermont as Healthier Living Workshops (HLW). Since that time, the

Blueprint Story – Human Services

One of the issues in a small town is transportation. Local doctor's offices, pharmacies, the local mental health counseling offices, and supermarkets are difficult for people who do not have reliable transportation to get to. To help solve this concern, a group composed of the case manager for the Blueprint for Health primary care medical office in town, the case manager for the mental health counseling office, and community social service organizations approached the local bus system about the need for a town bus service.

While figuring out the logistical details of the service took a few months, the bus now runs from 10 a.m. until 2 p.m. on Tuesdays, making multiple loops through town. All buses are wheelchair accessible. The bus stops at the local apartment complexes, so residents can start their journey to town close to where they live. This bus service allows patients to go from home to the primary care provider or mental health office, directly to the pharmacy to pick up a prescription, and with an optional stop at the grocery store before returning home again.

Scheduling patient appointments around a known bus schedule has made it easier for patients to avoid missing their appointments. Many of the delays experienced previously are no longer a concern. Those who have used the service so far have expressed satisfaction over the convenience of it.

Blueprint has expanded to support six group self-management programs, including:

- The Stanford *Diabetes* (2010) Healthier Living Workshop (HLW)
- The Stanford *Chronic Pain* (2011) Healthier Living Workshop (HLW)
- Vermont Quit Partners tobacco cessation in-person program (transitioned to Blueprint in 2011)
- Copeland Center Wellness Recovery Action Planning (WRAP)
- YMCA Diabetes Prevention Program (DPP)

In 2014, in an effort to increase uptake of the programs among Vermonters, the Blueprint expanded their strategic partnerships with the 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.

5.f.3. Stanford Chronic Disease Self-Management Programs – Healthier Living Workshops

The Stanford Self-Management Programs (Vermont's version is known as the Healthier Living Workshops) were created by Kate Lorig, DrPH, Professor of Medicine at Stanford University and her colleagues to enhance regular treatment and disease-specific education. The programs give participants the skills to coordinate and accomplish the things they need to manage their health, as well as to help them keep active in their lives.

The coping strategies introduced are applicable to all chronic diseases. Participants in all three variations of the HLWs make weekly action plans, share experiences, develop decision making skills, and help each other solve problems they encounter in creating and carrying out their self-management programs. Attendees are encouraged to come with a support person to improve their likelihood of successfully implementing the goals they have identified.

The workshops are designed to be led by peer, individuals with personal experience with chronic disease, who undergo standardized training and certification. The following three HLW program types are offered in Vermont:

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

- *Diabetes Self-Management Program/Healthier Living with Diabetes (2010)*
  This program focuses on teaching individuals with diabetes techniques to deal with the symptoms of fatigue, pain, hyperglycemia and hypoglycemia (high and low blood sugar),

stress, and emotional problems, such as depression, anger, fear, and frustration, in addition to those topics addressed in the general HLWs.

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

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

5.f.4. Tobacco Cessation

The Blueprint and the Vermont Department of Health (VDH) work collaboratively to ensure that a spectrum of tobacco cessation services, known as 802Quits, is offered and promoted to Vermonters. Together, the Blueprint and VDH implement Vermont Quit Partners, an in-person tobacco cessation program. Quit Partners sponsors hospital- or community-based group classes led by accredited tobacco treatment specialists who provide counseling, peer support, and free nicotine replacement therapy (NRT).

In addition to Quit Partners, 802Quits, supported by funding and resources from VDH, includes the Quitline (Quit by Phone), Quit Online, and Quit Your Way. Free NRT is available for every Vermonter through 802Quits.

Vermont Quit Partners offer statewide weekly group cessation classes facilitated by tobacco treatment specialists. Participants are assisted in preparing to stop using tobacco and are supported after they quit. Like other Blueprint self-management programs, Quit Partners provides a forum for peer support.

Quit By Phone (1-800-QUIT-NOW) links individuals with a quit coach at a time that works for them. Coaches provide five personalized calls (20-30 minutes each) and text support to help a smoker get ready to quit and to give tips, advice, and support on how to stay tobacco-free, including e-cigarettes.

Quit Online provides unlimited access to advice, tips, quit progress tracking, and an interactive forum where smokers can talk with other smokers who know what they are going through. Quit Online participants can also access phone coaches and use both services concurrently.

Quit Your Way provides smokers with tools and self-directed support to assist those that wish to try and quit on their own, available at 802Quits.org.

5.f.5. Wellness Recovery Action Planning (WRAP)

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

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

Participants organize personal wellness tools, activities, and resources they can use to help maintain well-being in the face of their symptoms. In addition, each participant develops an advanced directive that guides the involvement of family members, supporters, and health professionals in the event that the individual is not able to act on his or her own behalf.

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

5.f.6. YMCA Diabetes Prevention Program (DPP)

The Centers for Disease Control's Diabetes Prevention Program is a renowned, evidence-based program designed to help adults at high risk of developing Type 2 Diabetes in adopting and maintaining healthy lifestyle choices.

The program is delivered in a classroom setting by trained lifestyle coaches and provides a supportive environment where a small group of individuals work together. It has a specific focus on increasing physical activity (up to 150 minutes per week), healthier eating, and losing a modest amount of weight (7% of original body weight). The program lasts for one year and is composed of 16 weekly one-hour sessions followed by eight (8) monthly maintenance sessions.

In 2014, the Greater Burlington YMCA and the Blueprint continued their strategic partnership to offer the YMCA's Diabetes Prevention Program. The program has shown promising outcomes. The average weight loss has been 5.2% of body weight at completion of the 16-week core class and 5.9% of body weight at year end. More than 86.4% of participants reported improved overall health with 89.8% reporting reduced portion sizes and 83.1% reporting increased physical activity.

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

5.f.7. Summary of Self-Management Program Offerings

In 2014, 135 workshops (not including tobacco) were offered statewide, as shown in Table 10.

Table 10. Number & Type Self-Management Workshops

HSA	HLW Chronic Disease	HLW Chronic Pain	HLW Diabetes	WRAP	YDPP	Grand Total
Barre	4	3	4	3	3	17
Bennington	2	1				3
Brattleboro	1	2	1	2	0	6
Burlington	8	2	5	1	6	22
Middlebury	1	2	2	1	2	8
Morrisville	2	1	1		2	6
Newport	1		2			3
Randolph	2	1			1	4
Rutland	5	3	3	4	2	17
Springfield	2	1		3	1	7
St. Albans	4	1	1	2	2	10
St. Johnsbury	5	2			2	9
Upper Valley	2				1	3
Windsor	9	5		4	2	20
Total	**48**	**24**	**19**	**20**	**24***	**135**

**Note number of YMCA Diabetes Prevention Program workshops completed in 2014; 22 YCMA Diabetes Prevention Programs Started in 2014, some have yet to conclude.*

6. LEARNING HEALTH SYSTEM

The partners and stakeholders that work with the Blueprint program have made substantial progress towards a statewide *Learning Health System*, defined by the Institutes of Medicine as "a system in which science, informatics, incentives, and culture are aligned for continuous improvement and innovation, with best practices seamlessly embedded in the delivery process and new knowledge captured as an integral by-product of the delivery experience." – *IOM Learning Health Systems Series*

6.a. Blueprint Field Teams

This infrastructure includes the use of learning communities, data reports, the Expansion and Quality Improvement Program (EQuIP), and learning collaboratives, all of which are designed to promote a dynamic environment focused on disseminating best practices and on-going quality improvement. The core staffing infrastructure in each of 14 Health Services Areas includes a Blueprint Program Manager, a Community Health Team leader, practice facilitators, and local leaders of the CHT extenders (SASH, Spoke, and VCCI).

Forums are held at the state and local level to develop and disseminate practice innovations. These combined state and local regular working forums offer a system for the bi-directional, timely spread of information and innovation.

For Blueprint field team leadership and staff, the state-level meetings include:

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

These meetings focus on state updates, using data to drive improvement, and case studies from the field. In addition, these meeting highlight training needs. For example, during the CHT leader meetings, it came to light that most teams would benefit from skill enhancements in motivational interviewing and panel management, which resulted in Chittenden County offering training events on both of these topics for CHTs statewide in 2013 and 2014.

6.b. Integrated Health Services

In turn, within each HSA, the Project Managers and CHT leaders convene local meetings designed to develop efficient community networks, address gaps in care, and build community

resources. The Blueprint grants refer to these forums as the Integrated Health Services meeting, but each HSA has adopted its own name for this meeting. Typically these meetings occur monthly and multiple local partners participate – spanning Agency of Human Service's contractors and providers, transportation and housing organizations, and health care providers.

Originally intended as a Blueprint implementation committee made up of community partners to plan the development and expansion of the local Community Health Teams the purpose and focus of this meeting is evolving. The Blueprint and three ACO Provider Networks propose using these forums as the single regional clinical planning committee where requirements for all three ACOs are addressed. This forum then becomes a unified community collaborative, as discussed in Priority 1: Unified Community Health Systems starting on page 22.

Blueprint leadership at the state level is currently working closely with each HSA and the Provider Networks with a presence in each community to align their membership, goals, and work activities toward shared interests, including improvements in outcomes and reductions in unnecessary utilization and expenditures.

6.b.1. Semi-Annual Blueprint Conference

Now in its second year, in October 2014, the Semi-Annual Blueprint Conference convened over 200 local leaders for eighteen workshops for peer-to-peer knowledge sharing. Best-practice case studies were presented on a broad range of topics, including, but not limited to:

- In-depth explanation and use of the practice profiles
- Processes involved in mapping community networks within each HSA
- Improvements in patient care through panel management, care coordination, and co-management agreements between primary care practices and specialists
- Evidence-based approaches to substance abuse treatment, including community-wide narcotics protocols and use of the Screening, Brief Intervention, and Referral to Treatment (SBIRT) model
- Addressing and preventing trauma, including successful suicide prevention strategies, handling traumatic events, and support and services available to families with children
- Alignment of Blueprint and Provider Network/ACO activities at the local and state levels

6.b.2. SASH

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

- Motivational interviewing
- Aging well
- Effective communication
- Substance abuse and the use of medication

- Care for the caregiver
- Prevention and self-management of hypertension and pre-hypertension

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

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

6.b.3. Hub & Spoke (Care Alliance for Opioid Addiction Treatment)

The Blueprint and the Vermont Department of Health (VDH) Division of Alcohol and Drug Abuse Programs (ADAP) collaborated to create regular training and development forums for the five (5) regional specialty addictions treatment centers (Hubs) and the newly hired Spoke nurses and clinicians working with Vermont's buprenorphine providers.

With faculty leadership from the Dartmouth Health System's Addiction Medicine, monthly in-person and phone webinars bring program staff together for program improvement. The goal is to improve care in each practice setting and to standardize care across the statewide system. These networks provide a practical and efficient mechanism to drive improvements in the standard of care and to ensure coordination between providers statewide.

6.c. Data Reports to Practices and HSAs

6.c.1. Practice Profiles

In June 2013, the Blueprint added a powerful tool to its evaluation and quality improvement arsenal with the release of the Practice Profiles based on 2011 data. These reports, derived from Vermont's all-payer claims database, the Vermont Healthcare Claims Uniform Reporting and Evaluation System (VHCURES), allow individual practices to assess their utilization rates and quality of care delivered compared to local peers and to the state as a whole, giving them data to assist in honing their quality improvement efforts.

In 2014 two sets of profiles were released. The production is now more timely, with each new release reporting on information as recent as 6 months. The ongoing release of the profiles will give primary care practices participating in the Blueprint a longitudinal look at the outcomes gained compared to their peers. Blueprint practice facilitators use these profiles to work with their assigned patient-centered medical homes and hone in on best practices, while identifying areas for quality improvement projects.

Compared to previous versions of the Blueprint practice profiles, the version released in September 2014 contained two major enhancements:

- Data on the Medicare population
- A new page displaying practice trends

The inclusion of the Medicare population in the practice profiles marked the first time practices received *whole population* profiles with data from all payers combined into a single report. To clarify further, these profiles, completed in September 2014, included data for Vermont residents enrolled in commercial health plans, Medicaid enrollees for whom Medicaid was the primary payer (excluding duals), 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 geographical hospital service area (as defined by the Vermont Department of Health (VDH)) in which the practice is located. Practices are encouraged to use the data in the profiles to fuel quality improvement initiatives.

6.c.2. HSA Profiles

In April 2014, the Blueprint introduced 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.

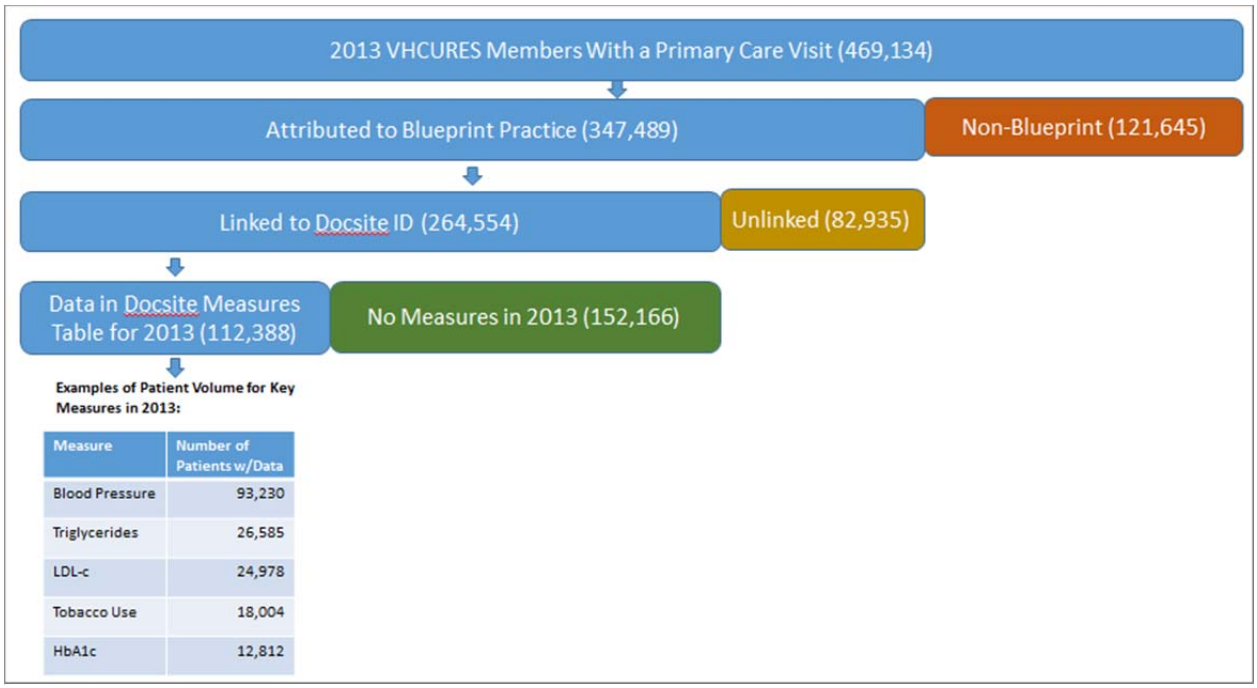
The introduction and release of the first set of HSA profiles garnered the attention and interest of Vermont's Provider Networks after their formation and during their planning process for how best to operationalize statewide data collection and reporting, especially for measures with a clinical component.

Given that the Provider Networks jointly agreed to and adopted consistent quality measures through the Vermont Health Care Innovation Project (VHCIP), the Blueprint worked with the Provider Networks on a plan to include a dashboard of ACO measures integrated into Blueprint HSA profiles.

To reduce the burden of clinical data collection for production of the ACO measures, often gathered through chart reviews at a practice level, the Blueprint tested whether an extract from the statewide clinical registry (DocSite) could be added to the claims data to produce clinical and hybrid measures. The clinical registry has been aggregating clinical data interfaced from primary care practice Electronic Health Records (EHRs) into the Vermont Health Information Exchange (VHIE), operated by Vermont Information Technology Leaders (VITL), for the last six years.

Upon analysis of the data in the clinical registry, after de-identification and linkage of individuals in DocSite (clinical records) with individuals in VHCURES (claims records), the Blueprint analytics vendor, Onpoint Health Data, determined the portion of the population for which clinical data was available and valid in DocSite, as shown below (Figure 20).

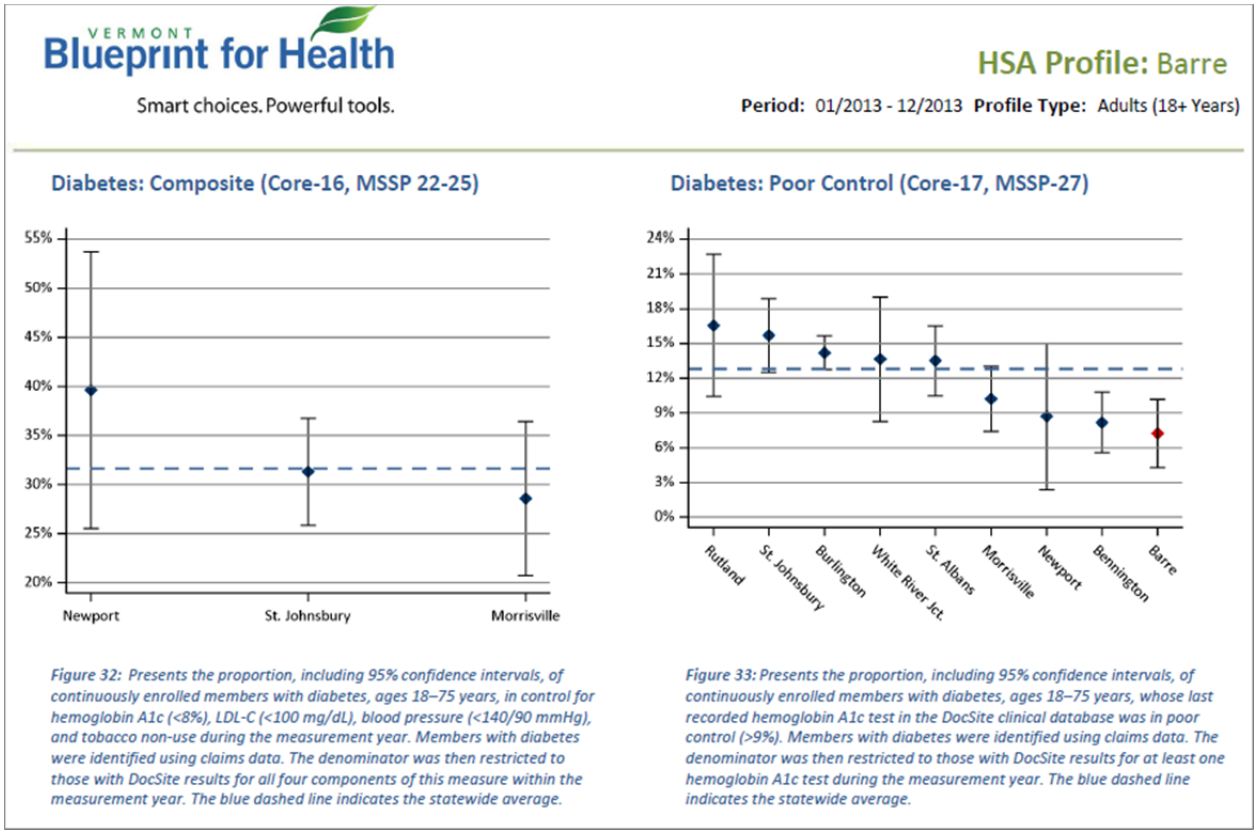
Figure 20. Step Down of Available Clinical Measures in DocSite for Individuals with a Primary Care Claim in VHCURES



Measure	Number of Patients w/Data
Blood Pressure	93,230
Triglycerides	26,585
LDL-c	24,978
Tobacco Use	18,004
HbA1c	12,812

Released in December 2014, the HSA Profiles for 2013 data displayed the first dashboard of ACO measures calculated from clinical data in DocSite, see Figure 21 for the Diabetes: Composite and Poor Control measures (Core ACO measures 16 and 17).

Figure 21. Sample ACO Measure Dashboard from 2014 Blueprint HSA Profiles



While data on hemoglobin A1c test results were available in DocSite for a large enough sample size of patients in 9 of the 14 HSAs, data for the diabetes composite measure, inclusive of hemoglobin A1c, LDL, blood pressure, and tobacco non-use during the measurement year, were only available in 3 of the 14 HSAs.

In addition to generating core measure results, this process helps to identify limitations on data quality and connectivity down to the specific practice site and organization. VITL and Blueprint data quality teams can use these gaps to target their work, identifying those HSAs and practices where clinical data is not being captured or sent to the VHIE and DocSite.

Most compelling, since Onpoint was able to link the clinical data with claims data for individuals having records in both DocSite and VHCURES, key metrics such as healthcare expenditures, rate of inpatient hospitalizations per 1000 members, number of inpatient days per 1000 members, and outpatient emergency department visits per 1000 members were calculated and compared side-by-side for subpopulations (Table 11).

Table 11. Comparison of Diabetic Patients by HbA1c Control Status, Statewide

Metric	Diabetes A1c in Control	Diabetes A1c not in Control (>9%)
Members	4,220	568
Annual expenditures per capita	$12,507 ($12,059, $12,954)	$15,267 ($13,867, $16,667)
Inpatient hospitalizations per 1,000 members	181.7 (168.7, 194.7)	275.0 (231.1, 318.8)
Inpatient days per 1,000 members	877.8 (849.2, 906.4)	1,524.0 (1,421.8, 1,627.2)
Outpatient ED visits per 1,000 members	532.1 (509.8, 554.4)	752.2 (654.0, 796.4)

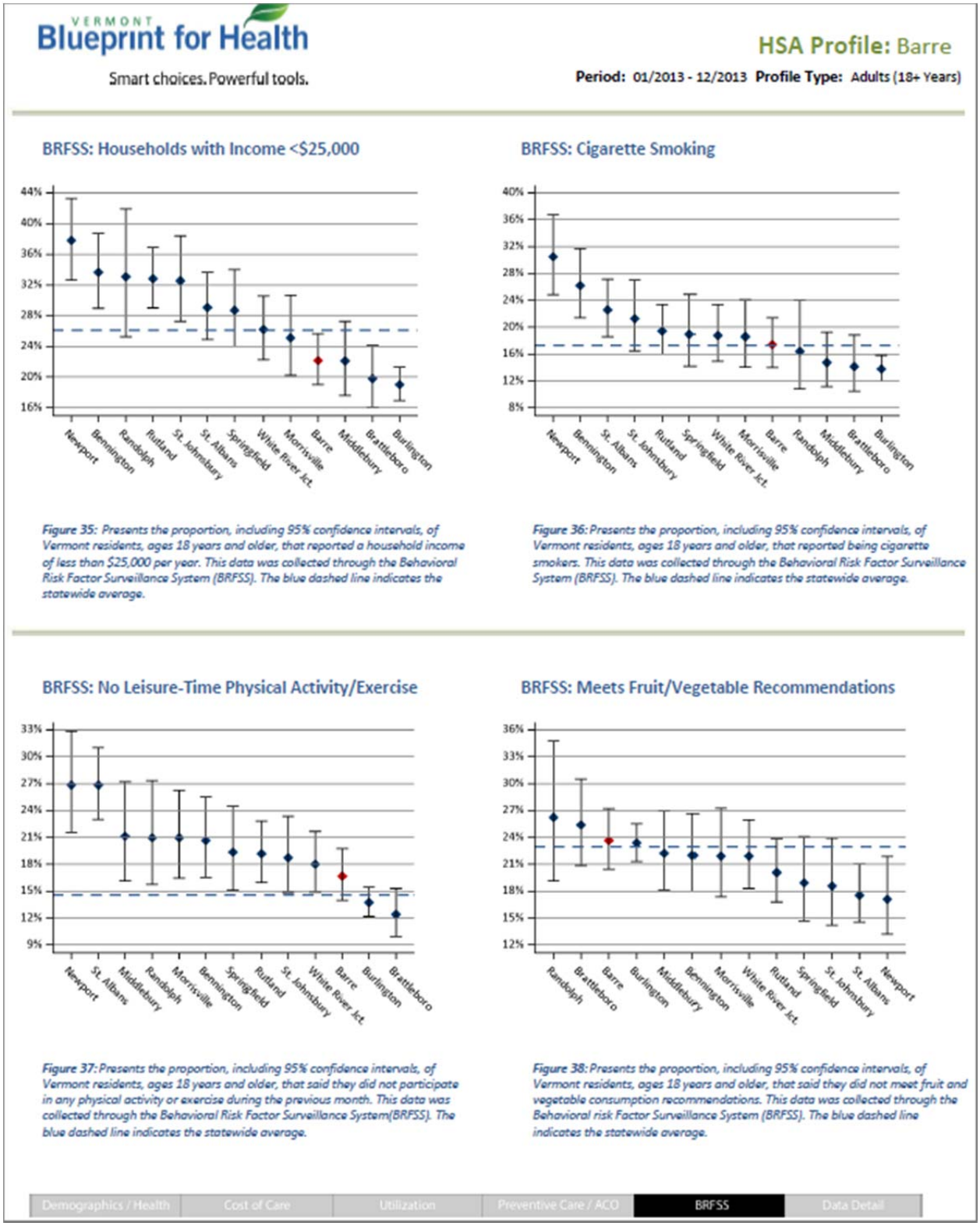
Note: Risk-adjusted rates with 95% confidence intervals are provided in parentheses. Outliers beyond the 99th percentile have been excluded.

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 (<8%) 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.*

The analysis shows a significant average annual cost increase of $2760 per diabetic patient with A1c not in control. It could also be used to focus efforts to reduce expenditures, hospitalizations, and emergency department visits for the 568 Vermonters whose diabetes is not in control. These types of cost comparison dashboards, using clinical and claims data, can be used to provide meaningful guidance for community- and practice-level quality improvement initiatives.

In addition to using the central clinical registry to generate ACO measures in the HSA profiles, the Blueprint also worked with the Vermont Department of Health (VDH) and Onpoint Health Data to include data from the Behavioral Risk Factor Surveillance Study (BRFSS), a telephone survey conducted annually by VDH (Figure 22).

Figure 22. BRFSS Data Displayed in Blueprint HSA Profiles



The regular production of timely HSA profiles across all payers and featuring ACO core measures and other key population health indicators can serve as a starting point for community-wide quality improvement initiatives.

Complete sets of both adult (ages 18 and older) and pediatric (ages 1 through 17) Blueprint HSA Profiles for each HSA, inclusive of all payers, can be found at http://hcr.vermont.gov/HSA.

6.d. Expansion and Quality Improvement Program (EQuIP) Practice Facilitator Team

Vermont has helped shape a national model supporting the transformation of primary care through the implementation of Practice Facilitation defined as:

> *"…a supportive service provided to a primary care practice by trained individuals or teams of individuals. These individuals use a range of organizational development, project management, and practice improvement approaches and methods to build the internal capacity of a practice to help it engage in improvement activities over time and support it in reaching incremental and transformative improvement goals."*[10]

Vermont's Expansion and Quality Improvement Program (EQuIP) consists of a team of practice facilitators who assist primary care internal medicine, family medicine, pediatric, naturopathic, and office-based opiate therapy practices with continuous quality improvement (QI) efforts. In 2014, 13 practice facilitators (10 full-time equivalents) have assisted practices with recognition by the National Committee for Quality Assurance (NCQA) as patient-centered medical homes, with process improvement for opioid addiction treatment and other clinical priorities, and an obstetrics and gynecology practice and Hub organization with NCQA specialty practice recognition.

The EQuIP team members come from such disciplines as social work, nursing, and education and are all highly skilled in change management and process improvement. Facilitators are trained to develop relationships and work on-site in practices with the providers they support, working with consistent practice-based teams as much as possible. Other communication mechanisms with individual practices, such as phone and email, are also used, especially for interim support and follow up.

A practice facilitator's charge is to build ownership and support for continuous QI in the practice. The QI projects are chosen by the practices and are based on their established goals. Practice facilitators guide practices to tailor established QI methodology for "in the trenches" practice settings and issues. By actively using these approaches, they teach the team to

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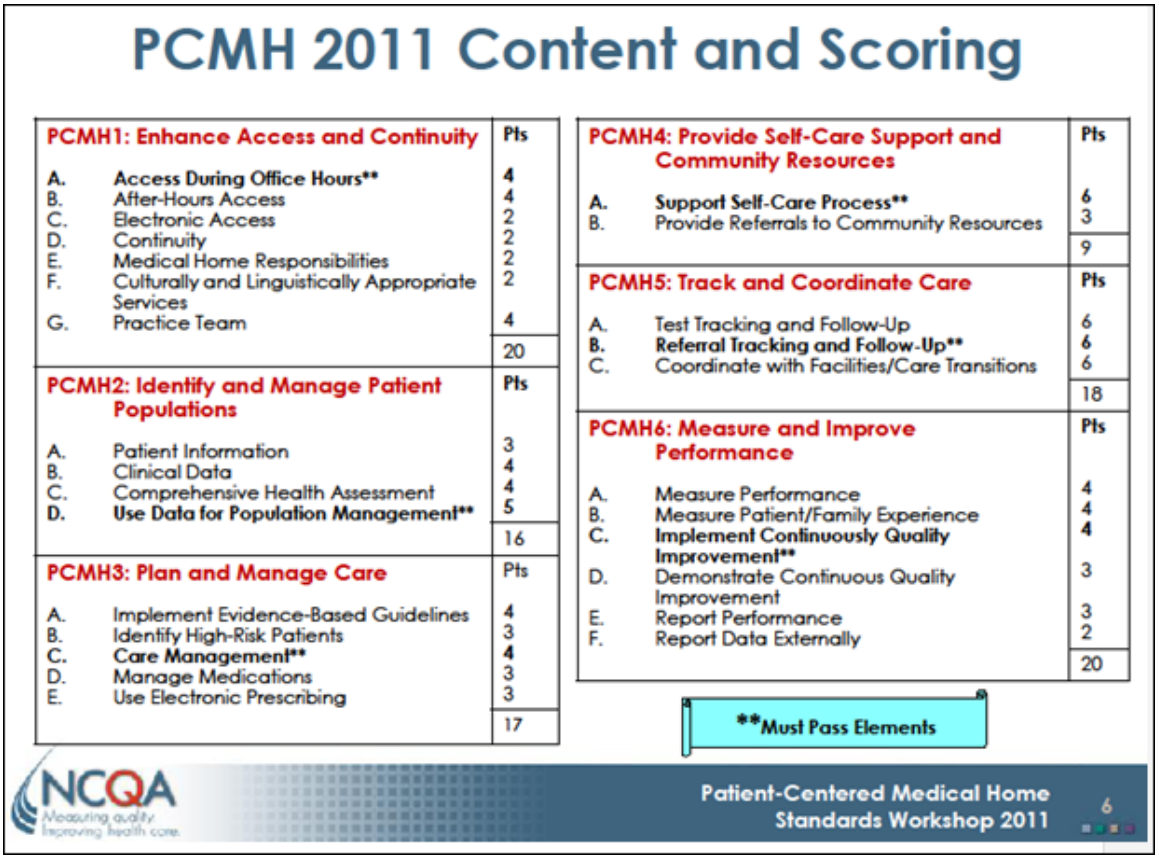
[10] *Developing and Running a Primary care Practice Facilitation Program*, published by the Agency for Healthcare Research and Quality (AHRQ) in 2011.

incorporate QI tools into daily workflows in order to improve care and measure change. Facilitators are a staff resource that can help translate visionary policy into real-world operations and sustained change. The goals most often addressed by facilitators and practices fall into three major categories:

- NCQA recognition - understanding and evaluating how well practices will perform against the NCQA PCMH standards and developing action plans and timelines to meet the standards
- Electronic systems integration - electronic health record (EHR) implementation and upgrades; reporting from the EHR; connecting to the Vermont Health Information Exchange (VHIE); interfacing to or entering data in the centralized clinical registry (Covisint DocSite)
- Improvements in clinical care - Pursuing improvements in the management of chronic conditions (including diabetes, asthma, hypertension, ADHD, depression, tobacco use, obesity, and others); immunizations; preventive services and screenings, such as wellness and well-child exams, lead screening, cervical cancer screening, breast cancer screening, BMI screening, colon cancer screening, autism assessments, and tobacco screening); and access to care (availability of same-day appointments, access by phone, and reduction of wait times and of avoidable ER use)

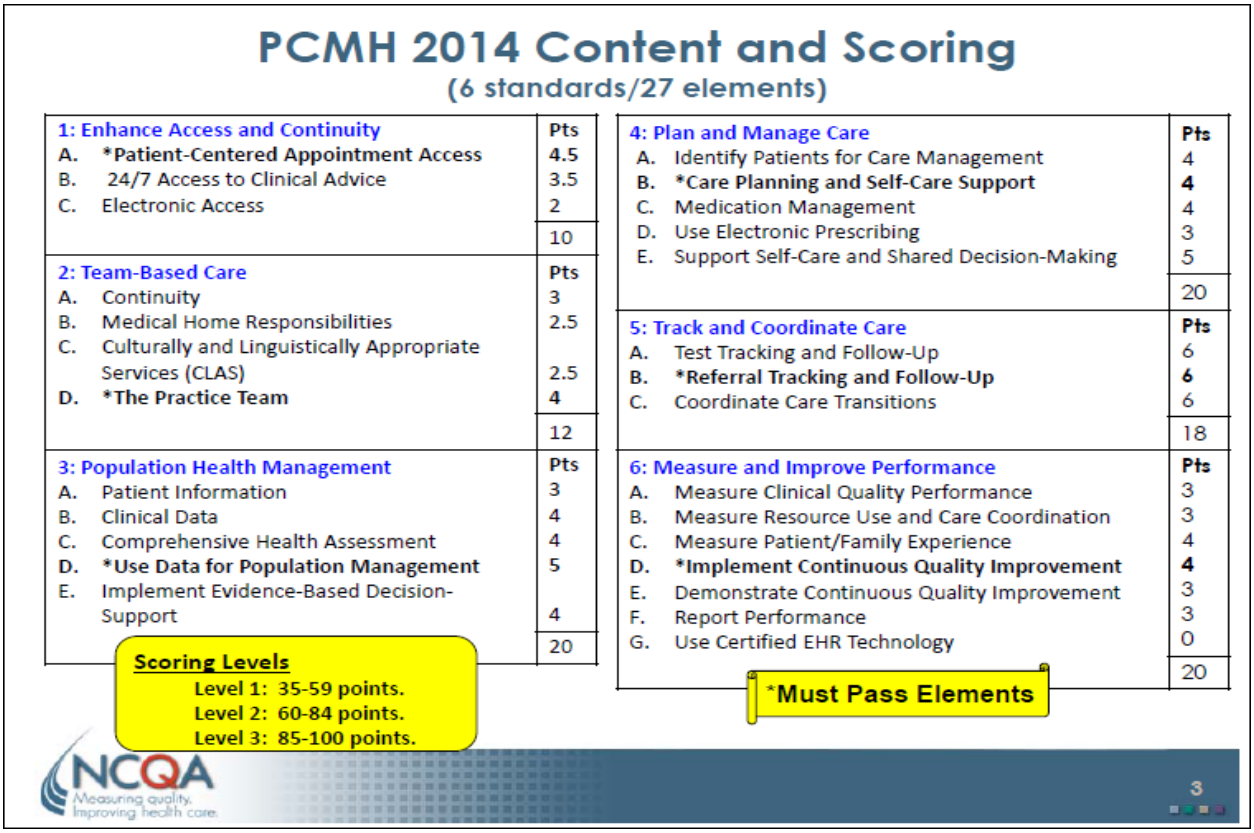
In 2012, NCQA modified the PCMH standards under which the practices are recognized. These 2011 standards (summarized in Figure 23) require mandatory and rigorous demonstration and clear documentation that the practices have both the capabilities and systematic implementation of the intent of each of the elements. In order to achieve recognition from NCQA as a Patient-Centered Medical Home a practice muse meet these “must pass” standards results. It is noteworthy that despite this higher threshold for recognition, Vermont practices have achieved this higher standard at exceptional levels when working with Blueprint practice facilitators.

Figure 23. Summary of 2011 NCQA PCMH Recognition Standards



Beginning in March 2015, Blueprint practices up for re-scoring will be recognized against the new 2014 standards (Figure 24), which require a practice to demonstrate sustained quality improvement efforts in alignment with the standards over time.

Figure 24. Summary of 2014 NCQA PCMH Recognition Standards



In addition, it is anticipated that some of the Hubs (addictions treatment centers) will be recognized under the NCQA specialty practice standards with the support of a facilitator in 2015.

Work with the practice facilitators continues after NCQA PCMH recognition. Practices identify their improvement goals, often informed by the NCQA scoring process and implementation and integration of the local CHT operations. Options for practices include individual projects with their facilitator and participation in learning collaboratives.

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

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

6.d.1. PCMH Case Study

NCQA-PCMH standards provide a framework for better care. The following case study, presented by a Blueprint practice, demonstrates how the PCMH+CHT model increases access to

primary care, connects individuals with critical medical and non-medical services, and facilitates team-based care.

Barbara (not her real name) is a 64-year-old woman with a history of trauma. Her primary care provider referred her to a CHT social worker when Barbara's life circumstances began preventing her from keeping medical appointments.

During Barbara's first visit, the social worker learned that Barbara, recently widowed, had been experiencing financial difficulties, suffering from depression due to her recent loss, and smoking heavily. She was socially isolated and dependent on busy, sometimes impatient, acquaintances that she paid for rides. When family and friends did visit her, they smoked heavily around her.

The CHT social worker helped Barbara effectively use her Medicaid transportation benefit. As a result, Barbara now schedules her rides, attends her medical appointments, and communicates more directly with her primary care provider.

At a follow up visit, the CHT social worker suggested that Barbara attend smoking cessation classes offered at the local hospital. A community health planner helped her secure rides with another attendee from her town. They have since become friends and graduated from the class together. Due to her success in quitting smoking, Barbara was asked to attend and speak to the next smoking cessation class.

Since graduating from her smoking cessation class, Barbara has maintained nearly six months of a smoke-free lifestyle and says she is thrilled with her accomplishment. She recently met with a CHT nutritionist to continue her progress towards wellness and health. Along the way, her depression has improved as well. The nutritionist referred her to and encouraged her to access the local Area Agency on Aging for funds to attend her local senior center, where meals are provided and socialization opportunities exist.

In short, Barbara's empowerment to reengage in life, her renewed confidence, and her focus on living a healthy, active life has been buoyed by the comprehensive supports available through the Blueprint programs.

6.e. Community Network Analysis

While the CHT, SASH, Practice Facilitators, and Spoke staffs interact on a daily basis with primary care practices and a wide network of health and human services providers, the Blueprint historically lacked a quantifiable way to measure the strength of these referral networks within each HSA. In 2013, as part of the Blueprint program evaluation, contracted researchers trialed a new methodology for mapping and measuring community networks.

6.e.1. The Challenge of Measuring Community Networks

In addition to directing the activities of core CHT staff, the Blueprint Project Manager and CHT Leader from each HSA engage a broad group of community leaders and health and human services professionals in regular local meetings designed to build knowledge of available resources, improve coordination between service providers, and identify gaps and unmet community needs.

By formalizing this convening role, the Blueprint expands and strengthens the existing health and human services networks in each community. Anecdotal (qualitative) evidence abounds for the importance of this role and activity, but community network development had been uniquely difficult to quantify.

6.e.2. Mapping and Measuring Blueprint Communities Using Network Analysis

Network Analysis offers an opportunity to visualize the community networks and quantify overall connectedness and the position of key organizations. The methodology includes a survey of community partners in each HSA, as identified by the Blueprint Project Manager and CHT Leader.

Conducted for the first time in 2013, representatives of each partner organization identified were asked to indicate how their organization interacts with each of the other organizations in four distinct ways:

- Sharing information
- Sharing resources
- Sending referrals
- Receiving referrals

The researchers then mapped relationships using network analysis software (Gephi and UCINET). A force-based algorithm pulled connected organizations closer together and pushed unconnected organizations further apart, creating a picture representing each organization in a position that takes into account its relationship to every other organization in the network. This relationship is quantified in several ways, most importantly a centrality score.

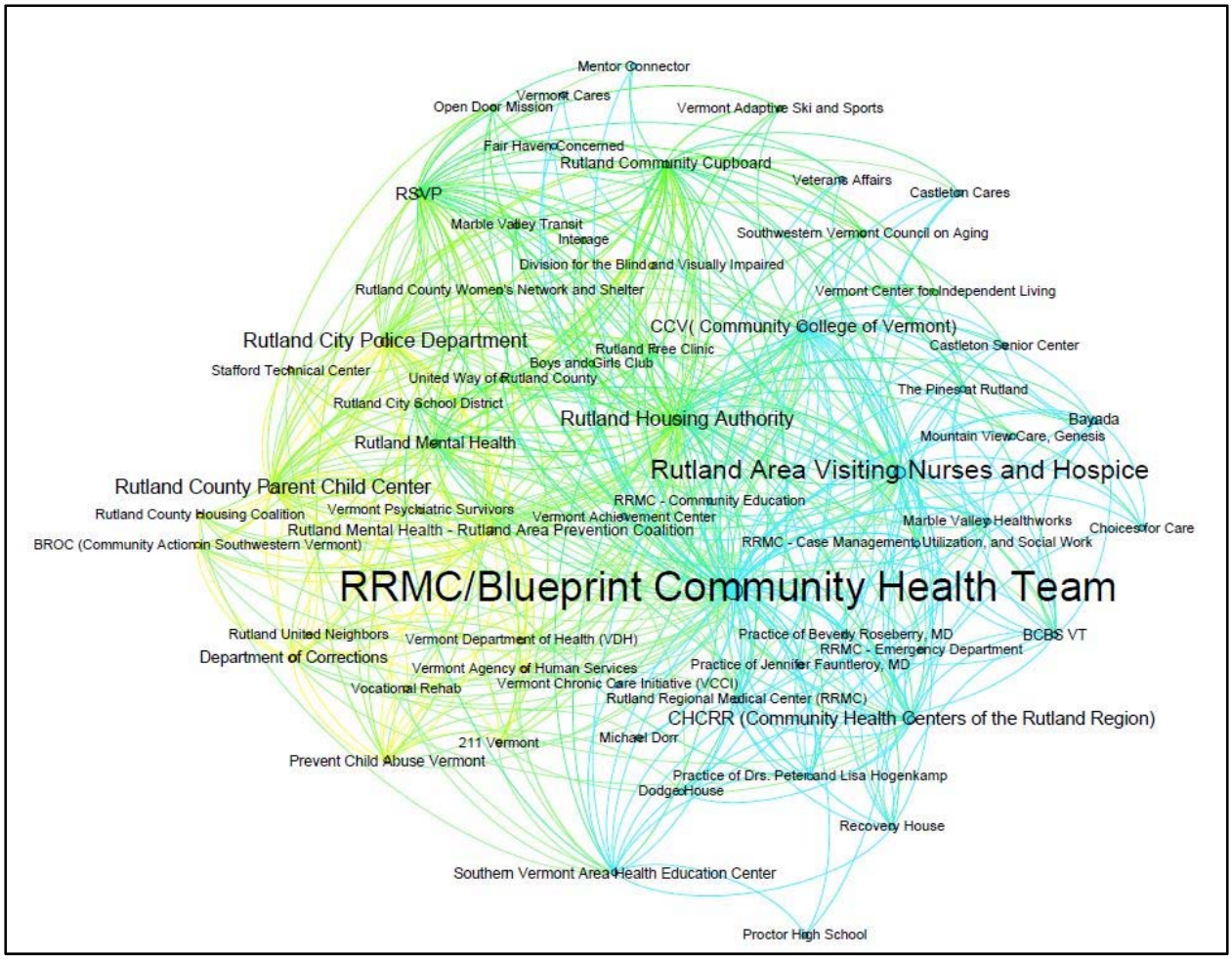
Measures of individual organization's positions in the network include centrality in the network, degree of connectedness, and key player status. Useful measures of the overall HSA network include:

- Network density
- Average degree of connectedness
- Modularity (meaning the presence and strength of sub-networks or neighborhoods within the larger network)

Any of these measures may be compared across communities, presenting the possibility of identifying characteristics of high-functioning networks.

Figure 25 shows the community network map for the Rutland HSA that resulted from the Blueprint's 2013 network analysis research.

Figure 25. Rutland HSA Community Network Map



6.e.3. Community Facilitation

Results of the first round of network analysis research were shared with each community in forums where the research, and particularly the maps, was used as a starting point for conversations about the nature of collaboration in their community. Reflection and evolution questions addressed organization centrality, responsibilities associated with centrality, which relationships are strong versus those that are weak, and identification of missing links.

In particular, during these forums, communities examined the question: does the mapping of relationships within the community's network reflect the ideal scenario for overall community

health? The forums also examined sub-networks and their role in the larger network, as well as missing organizations and resources that need to be drawn into the network. The goal of these interventions was to inform and support planned networks.

6.e.4. Opportunities for Connecting the Community Network Structure with Health Outcomes

With proof-of-concept Network Analysis and community network mapping available as a tool in planned, purposeful community network development, the Blueprint is engaging in a second round of this study in 2014. Based on lessons learned from the 2013 study, improvements to the 2014 network analysis approach include:

- A more rigorous list development methodology for community partner organizations working with the Blueprint
- Pursuit of a dataset that can be associated with health outcomes measures, allowing for:
    - Investigation of key questions about the impact of CHTs
    - Analysis based on the position of various health and human services providers in the networks
    - Identification of community relationships and partnerships that best support high-quality, controlled cost healthcare and positive patient experiences

The Blueprint will continue to share data back with the communities, both in HSA Profiles beginning in June 2015 and via community meetings where dialogue about network structure and impact will support the developing role and work of emerging unified community collaboratives.

6.f. Learning Collaboratives

Widely used to improve care for targeted conditions in primary care settings, Learning Collaboratives involve convening teams of a physician leader, nurse, office manager, and other staff from four to up to ten practices. They participate in a facilitated structured process of didactic learning, rapid trial implementation cycles (known as Plan Do Study Act, or PDSA), and measurement of the impact of process changes over several months.

The practices agree to collect data across a common set of quality of care measures, to identify and test practice improvements in each participating practice, and to share data and measurement about practice changes with each other. The process accelerates practice improvement in applied settings and often results in a core team able to collaborate across organizational boundaries on the implementation of common care standards.

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

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

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

To support the Hub & Spoke practice reforms, the Blueprint (in collaboration with the VDH Division of Alcohol and Drug Abuse) convened six regional learning collaboratives focused on Medication Assisted Treatment (MAT) for opiate addiction in 2013 and 2014.

Over thirty-five (35) Spoke Practices and all Hub programs have sent or are sending teams with physicians, nurses, medical assistants, and office managers to the Opioid treatment collaboratives with twenty-nine (29) physician leaders attending most sessions with teams. The second year curriculum includes the following topics:

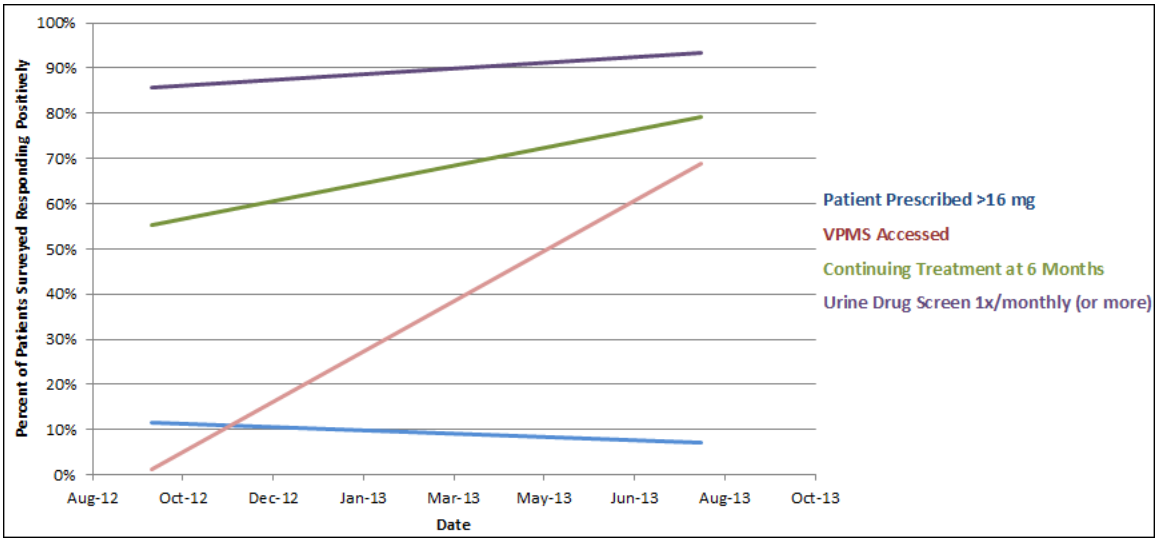
- Pregnancy and buprenorphine
- Chronic pain and management of pain for individuals with addiction
- Treating anxiety in patients addicted to opioids
- Managing other substances of abuse (alcohol, THC, etc.) in patients with opioid addiction
- Supporting Recovery

The collaboratives take place over ten (10) months and consist of four to five half-day in-person sessions and five one-hour webinars. The content includes didactic lectures, case examples, and presentations about how best practice is implemented in clinical care. In addition, each practice reports on common measures important to evidence-based care.

The opioid addiction treatment collaborative included measures for use of the Vermont prescription monitoring system (VPMS), monthly urine analysis, treatment retention, and rates of patients receiving above the recommended dose or more than 16 mg of Buprenorphine daily (a risk for diversion).

The current collaboratives are also measuring travel time to care and use of benzodiazepines (contraindicated when buprenorphine is prescribed). Throughout the collaborative, practices work to improve their performance on these measures and other aspects of care. These collaboratives proved to be a powerful tool to improve the standard of care for opioid addiction rapidly. Figure 26 below shows the improving trend for selected learning collaborative measures.

Figure 26. Four Key Metrics from MAT Collaborative



7. BLUEPRINT PAYMENT REFORMS

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

As of 2013, the two planned Blueprint payment reforms (for Transformation and Capacity) are implemented statewide and sustained through enacted Vermont statute. These innovative financial reforms align fiscal incentives with healthcare goals. All major commercial insurers, Medicare, and Vermont Medicaid participate. These targeted payment streams are designed to achieve specific outcomes with clear incentive structures that promote the stated Blueprint goals, including quality, access, communication, and patient-centered services.

The two specific streams of enhanced financial support to primary care practices are as follows and are illustrated in Figure 27. The payments are in addition to the existing fee-for-services billing.

Per Patient Per Month (PPPM) payments are made to providers based on the scoring level achieved by the primary care practice in NCQA-PCMH Recognition standards (Tables 12 and 13). This payment incents practices to improve quality against national standards. It promotes access, communication, guideline-based care, well-coordinated preventive health services, use of electronic tracking systems, and population management.

All insurers share the cost for core Community Health Team (CHT) – and as such, is a payment for capacity. The shared funding for CHT is provided at the rate of $70,000 (~1.0 FTE) / 4000 patients, which amounts to about $1.50 per patient per month. This Capacity payment reform establishes a community-based care support infrastructure available to primary care practices and the general populations they serve. The CHT is supported 6 months prior to a practice's NCQA score date, further underscoring the Blueprint partners' commitment to the spread of quality improvement. This payment is routed to an administrative entity in each health service area to support community health team operations.

Figure 27. Blueprint Payment and Delivery System Reforms

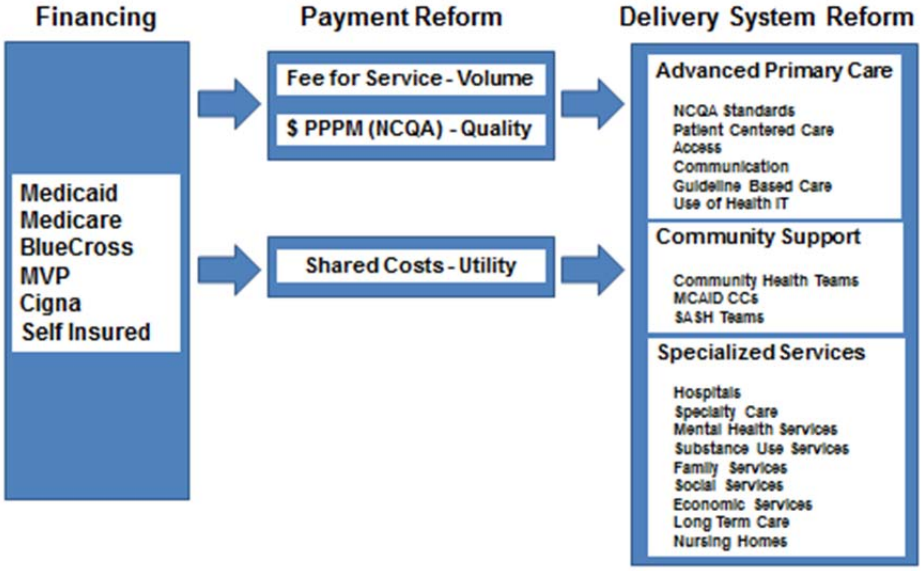


Table 12. $ PPPM for Each Provider (Based on NCQA-PCMH 2008 Standards)

NCQA PPC=PCMH Score in Points	Average PPPM in $	NCQA Level	Number of Must Pass Elements
0	0.00	N/A	N/A
5	0.00	N/A	N/A
10	0.00	N/A	N/A
15	0.00	N/A	N/A
20	0.00	N/A	N/A
25	1.20	1	5 out of 10
30	1.28	1	5 out of 10
35	1.36	1	5 out of 10
40	1.44	1	5 out of 10
45	1.52	1	5 out of 10
50	1.60	2	10 out of 10
55	1.68	2	10 out of 10
60	1.76	2	10 out of 10
65	1.84	2	10 out of 10
70	1.92	2	10 out of 10
75	2.00	3	10 out of 10
80	2.07	3	10 out of 10
85	2.15	3	10 out of 10
90	2.23	3	10 out of 10
95	2.31	3	10 out of 10
100	2.39	3	10 out of 10

Table 13. $ PPPM for Each Provider (Based on NCQA-PCMH 2011 Standards)

NCQA PPC=PCMH Score in Points	Average PPPM in $	NCQA Level	Number of Must Pass Elements
0	0.00	N/A	N/A
5	0.00	N/A	N/A
10	0.00	N/A	N/A
15	0.00	N/A	N/A
20	0.00	N/A	N/A
25	0.00	N/A	N/A
30	0.00	N/A	N/A
35	1.36	1	6 of 6
40	1.44	1	6 of 6
45	1.52	1	6 of 6
50	1.60	1	6 of 6
55	1.68	1	6 of 6
60	1.76	2	6 of 6
65	1.84	2	6 of 6
70	1.92	2	6 of 6
75	2.00	2	6 of 6
80	2.07	2	6 of 6
85	2.15	3	6 of 6
90	2.23	3	6 of 6
95	2.31	3	6 of 6
100	2.39	3	6 of 6

On October 1, 2014, in accordance with Act 144, Section 17, the Blueprint, in collaboration with the Agency of Administration and the Green Mountain Care Board, submitted a report to the House Committees on Health Care and on Human Services and the Senate Committees on Health and Welfare and on Finance of the Vermont legislature. As requested in statute, this report contained recommendations on "whether and to what extent to increase payments to health care providers and community health teams for their participation in the Blueprint for Health", since practice PPPM payments and CHT payments have remained static since 2008.

Recommendations and options for payment increases and payment model modifications as outlined in the October report can be found in Priority 3: Options for Payment Modifications.

8. HEALTH INFORMATION TECHNOLOGY

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

8.a. Interface Connections from Blueprint Practice EHRS to the VHIE

One important part of the infrastructure is the Vermont Health Information Exchange (VHIE), which is operated by Vermont Information Technology Leaders (VITL). The Blueprint and VITL continue their collaborative relationship, providing connectivity to the Vermont Health Information Exchange (VHIE) and assisting Blueprint practices with improving the quality of data that are being sent to the Blueprint clinical data repository.

With the assistance of the Blueprint, VITL connects practice Electronic Health Record (EHR) systems to the VHIE via three different types of interfaces:

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

During 2014, 51 new interfaces were established between Blueprint practices and the VHIE. Of those interfaces, 20 are demographics information (ADT) interfaces and 31 are clinical care summary document (CCD) interfaces.

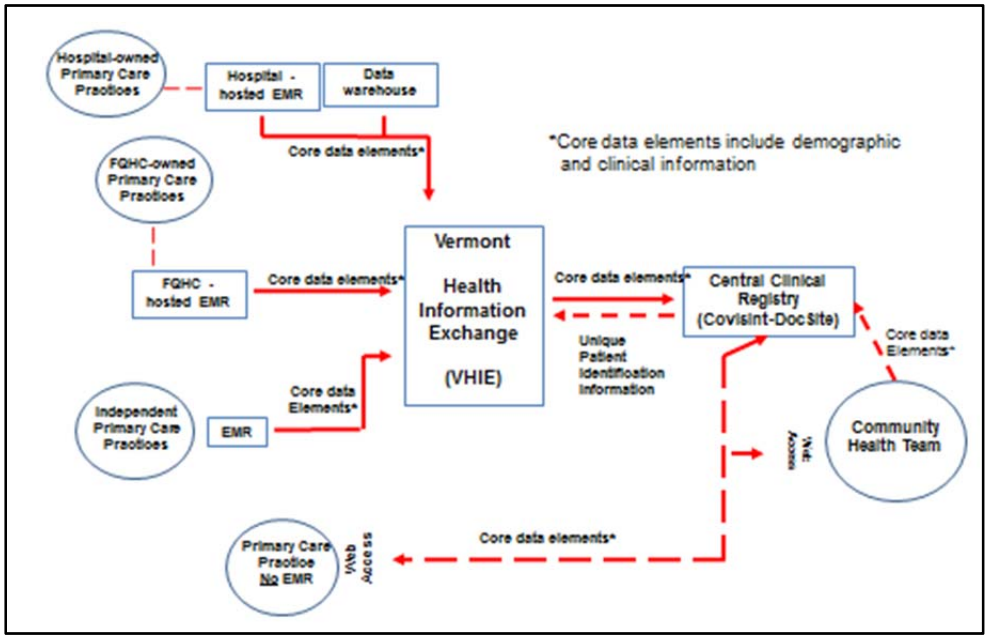
The keys to accelerating the number of interface connections in 2014 were economies of scale. Breakthroughs with major EHR system vendors, such as Medent and Allscripts, allowed the connections of multiple sites. For practices on the Medent EHR system, 17 interfaces were connected for 9 healthcare locations in 2014. For practices on Allscripts, 14 interfaces for 12 healthcare locations were connected. Likewise, connecting to multiple locations within an organization sped progress (Table 14).

Table 14. 2014 Interface Connections for a Single Organization with Multiple Locations

Organization Owning Physician Practices	# of interfaces	# of practice locations
Brattleboro Memorial Hospital	11	6
Community Health Centers of Burlington	8	4
North Country Hospital	6	5
Northwestern Medical Center	6	3
Primary Care Health Partners	8	8

Vermont's central clinical registry, known as Covisint DocSite, is one end-point for demographic and clinical data from the VHIE. DocSite serves as a reporting engine with the capability for population health analysis across the state. In addition to data coming from interfaces with the VHIE, Blueprint primary care practices can send information to DocSite via interfaces and flat files, while program users, such as SASH, CHT, and TCC can perform direct manual data entry. Figure 28 shows a schematic of Vermont's statewide clinical HIT infrastructure.

Figure 28. Clinical Health Information Technology Schematic Diagram



8.b. End-to-End Healthcare Information Transmission – Data Quality

8.b.1. Data Quality Project ("Sprint") Introduction

Data quality in practice EHRs and the VHIE is essential. Newer team-based care models rely on their IT systems with accurate data to generate lists (or reports) of patients that need attention, such as women over 50 who are overdue for a mammogram or diabetics who need an office visit to take blood pressures or other tests. Good quality data is also required for reliable outcome measurements and comparative effectiveness analyses.

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

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

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

8.b.2. Current Sprint Projects

During 2014, an improved process and focus led to the completion of Sprint projects at 31 healthcare locations. The ongoing two-year project total of completed Sprints stands at 28, affecting 80 clinical practice sites representing two-thirds of all eligible practices in Vermont.

There are two different types of Sprint projects:

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

In 2014, the Sprint Management Team had initially targeted 5 Remediation Sprints and 10 Onboarding Sprints for completion. The team met 115% of its stated goals. As of December 2014, 6 remediation and 15 onboarding Sprints have been completed involving a total of 65 practice sites, approximately 330,000 patients, and 9 EHR systems (Table 15).

Table 15. Sprint Projects Completed in 2014

Blueprint Sprint Program 2014		
Health Service Area	**Healthcare Organization**	**Clinical Sites**
Springfield	Springfield Medical Care Systems	Sites - 6
Burlington	Community Health Centers Burlington	Sites - 4
Rutland	Community Health Centers Rutland Regional	Sites - 5
Bennington	Southern Vermont Medical Center - Deerfield	Sites - 1
Multiple	Prmary Care Health Partners	Sites - 8
Bennington	Southern Vermont Medical Center - Medical Associates	Sites - 1
Barre	Central Vermont Medical Center	Sites - 5
Burlington	Thomas Chittenden Health Center	Sites - 1
Middlebury	Middlebury Family Health	Sites - 1
Burlington	Richmond Family Medicine	Sites - 1
Rutland	Hogenkamp Family Medicine	Sites - 1
St. Albans	Fairfax Associates in Medicine	Sites - 1
St. Albans	Max Bayard MD-PC	Sites - 1
St. Albans	Northwest Medical Center Practices	Sites - 3
Newport	North Country Practices	Sites - 13
Brattleboro	Brattleboro Memorial Hospital	Sites - 11
Upper Valley	White River Family Practice	Sites - 1
St. Albans	Cold Hollow Family Practice	Sites - 1
Middlebury	Rainbow Pediatrics	Sites - 1

In 2015, the Sprint Management team plans to complete the data quality, remediation, and onboarding of the remaining eligible practices in Vermont. Currently, there are 8 healthcare organizations that have begun the Sprint process of onboarding their demographic information in 2014 and will be working on the submission of clinical data and data quality in the early part of 2015.

As Sprint projects complete, an additional 8 sites will be added to the program. In addition, two sites have acquired new EHR systems and are in the installation process. The Sprint team will be assisting these sites in performing data migration, focusing on quality initiatives, and establishing the required interfaces. In total, the Sprint Management team has a goal of completing 18 Sprints in 2015 (2 Remediation Sprints and 16 Onboarding Sprints) in addition to two new EHR implementations, accounting for 43 practice sites (Table 16).

Table 16. Sprint Projects Planned for 2015

Blueprint Sprint Program 2015		
Health Service Area	**Healthcare Organization**	**Clinical Sites**
Windsor	Mt. Ascutney Hospital and Health Center	Sites - 2
Windsor	Grace Cottage	Sites - 1
Middlebury	Porter Medical Center	Sites - 13
Burlington	Alder Brook Family Health	Sites - 1
Bennington	Shaftsbury Medical Associates	Sites - 1
Morrisville	Community Health Services of Lamoille Valley	Sites - 3
Windsor	Little Rivers Health Care	Sites - 5
Morrisville	Paul Rogers	Sites - 1
Bennington	Batten-kill	Sites - 1
Randolph	Gifford Medical Center	Sites - 9
Bennington	Southern Vermont Medical Center Pediatrics	Sites - 1
Bennington	Brookside Pediatrics	Sites - 1
Burlington	Charlotte Family Health	Sites - 1
Bennington	Keith Michl MD-PC	Sites - 1
Burlington	Good Health PC	Sites - 1
St. Johnsbury	Northern Vermont Regional Medical Center (Completed 2013 New EMR Restart)	Sites - 9
St. Johnsbury	Northern Couties Health Care (Completed 2013 New EMR Restart)	Sites - 5

8.b.3. Core Data Quality

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

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

Admission, Discharge, and Transfer (ADT) Data

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

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

Clinical Data

Major issues encountered with the clinical data center around unstructured or free-text data entry into the EHR, disparate nomenclatures used by medical records systems for structured data entry, and the packaging, transmission, and acceptance of that data by other systems consuming it.

Since data quality issues vary from one EHR or information system to another and from one practice to another within a healthcare enterprise, the Sprint team addresses each community and

its medical information systems with a plan of action designed to identify problems and incompatibilities with the data and establish a baseline from which the team can work and measure improvement.

The Blueprint has made a commitment to continue and expand end-to-end data transmission and quality efforts through the Sprint process for all of 2015.

8.c. Central Clinical Registry (Covisint DocSite)

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

The registry is based upon the Blueprint data dictionary and condition measure sets. The product includes data elements for clinical processes and health status adopted directly from various national guidelines for preventive health maintenance and the treatment of chronic conditions.

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

As of November 2014, the SASH Dashboard reports went Live in DocSite, providing SASH with essential population-based performance reporting on defined measures to evaluate the effectiveness of the SASH program for all participants in Vermont and to allow for drill-downs into areas requiring attention, such as participants due for a flu shot and those with multiple emergency department visits within a particular measurement period.

Most notably, in May 2014, Covisint took a full extract of Vermont's DocSite database and delivered it to Onpoint Health Data for analysis and merging of claims and clinical data. Representatives from Covisint, Onpoint, and the Blueprint Sprint Management team worked together to interpret the data in DocSite and verify its validity and quality. Where measures are available for patients in DocSite, the data has proven to be of high quality. As a result, Onpoint used this data to produce clinical ACO measures for the 2014 HSA Profiles. Refer to HSA Profiles starting on page 84 for more detailed information on this project.

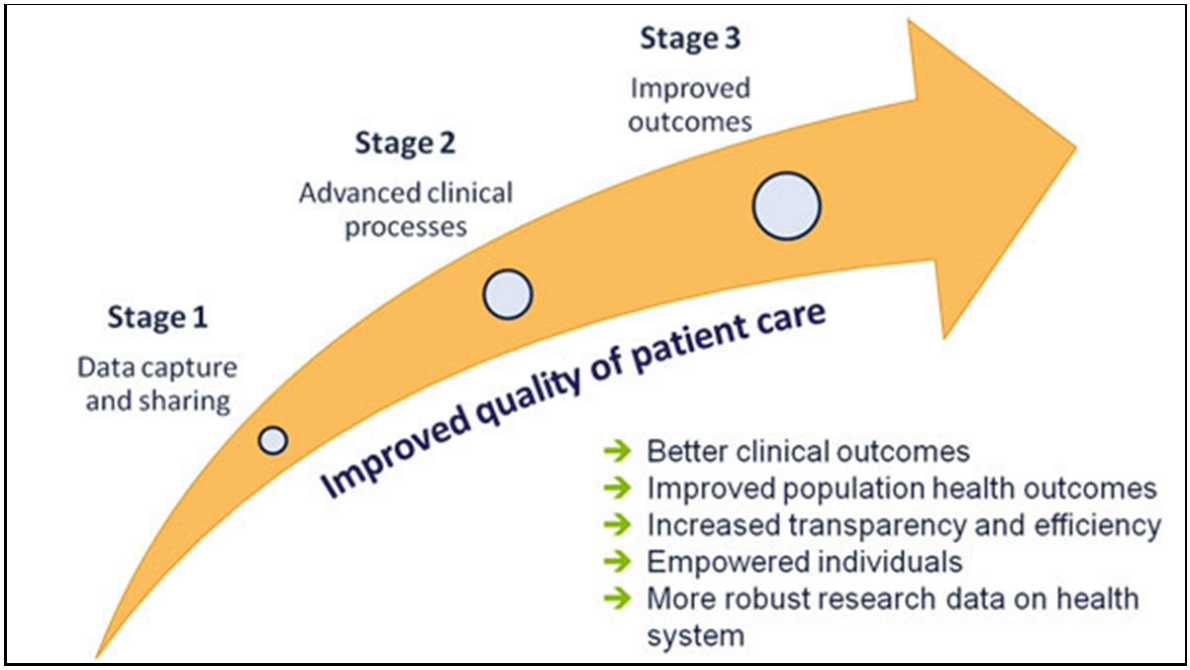
8.d. Electronic Health Record Incentive Program (EHRIP)

The EHRIP team is responsible for the implementation of the Vermont Medicaid Electronic Health Record Incentive Program (EHRIP). Established by the 2009 Health Information Technology for Economic and Clinical Health (HITECH) Act of the American Recovery & Reinvestment Act (ARRA), the program is designed to support providers during the transition to electronic systems and to improve the quality, safety, and efficiency of patient healthcare through the use of electronic health records (EHRs).

The EHR Incentive Program provides incentive payments to eligible professionals, eligible hospitals, and critical access hospitals as they adopt, implement, upgrade, or demonstrate meaningful use of certified EHR technology.

To receive an EHR incentive payment, providers must demonstrate they are "meaningfully using" their certified EHR technology by meeting certain measurement thresholds, which range from recording patient information as structured data to exchanging summary of care records. CMS has established these thresholds for eligible professionals and eligible hospitals. Meaningful Use objectives and measures evolve in distinct stages (Figure 29).

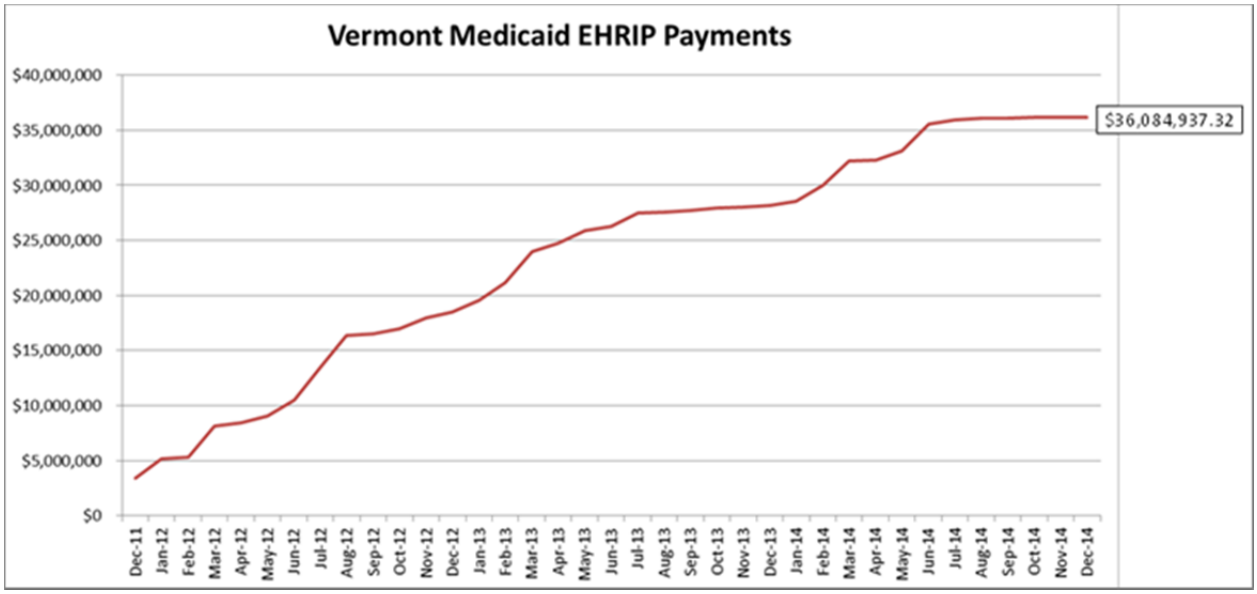
Figure 29. The Meaningful Use Arrow of Progress



The Medicaid and Medicare EHRIP programs produce federally-standardized, provider-level, Meaningful Use clinical quality measure (CQM) data.

Through 2014, the Vermont Medicaid EHRIP team has issued over $36 million dollars in incentive payments to eligible professionals and eligible hospitals (Figure 30).

Figure 30. EHRIP Payments Issued – December 2011 through December 2014



Much of the data flowing into the VHIE and DocSite comes from EHR systems reflecting the participation of providers in the EHRIP program.

8.e. VITLAccess and Patient Consent to View Policy

During the second half of 2014, VITL began the statewide rollout of VITLAccess, a new provider portal component of Vermont's HIE infrastructure. VITLAccess allows participating providers to see an integrated, patient-centric view of information reported to the Vermont Health Information Exchange (VHIE), informing healthcare decisions at the point of care.

VITLAccess is the culmination of a significant investment in the Vermont HIE by both the state and federal governments. The functionality provided by VITLAccess represents a critical step in achieving both state and federal healthcare reform goals related to the Triple Aim (improving the experience of care, improving the health of populations, and reducing per capita costs of healthcare). In order for these expectations to be realized, healthcare providers must be well-versed in the use, capabilities, and functions of VITLAccess.

Providers using VITLAccess have a view into the most timely, accurate, relevant, and comprehensive information about their patients generated by healthcare providers across Vermont. The successful onboarding of providers into VITLAccess will depend on the integration of VITLAccess into providers' daily workflows and the implementation of the state's patient consent policy. This work includes initial education and training, conveyance of best practices, and advice and guidance.

Patient written consent is required for his or her provider access to this level of statewide health information.

In March 2014, the Green Mountain Care Board (GMCB) revised the statewide consent policy from organization-level consent to a global consent. Under the revised policy, once a patient grants consent to one provider, any provider involved in the patient's care and with a user account in VITLAccess may legally access all data for that patient. More information about patient consent can be found at www.vitl.net/privacy. So far, over 8000 patients have given their consent for their providers to access their healthcare information using VITLAccess.

As of December 2014, 11 organizations within the state are actively using VITLAccess. These organizations represent multiple care settings, ranging from a hospital and their hospital-owned physician practices, two primary care practices, one pediatrics practice, two specialty care practices, two chiropractic practices, a physical therapy facility, a skilled nursing facility, and a home health and hospice care facility.

As of November 30, 2014, about 275 VITLAccess subscribers have used the system, and this number is expected to increase dramatically in 2015 as the rate and pace of enrolling new providers accelerates.

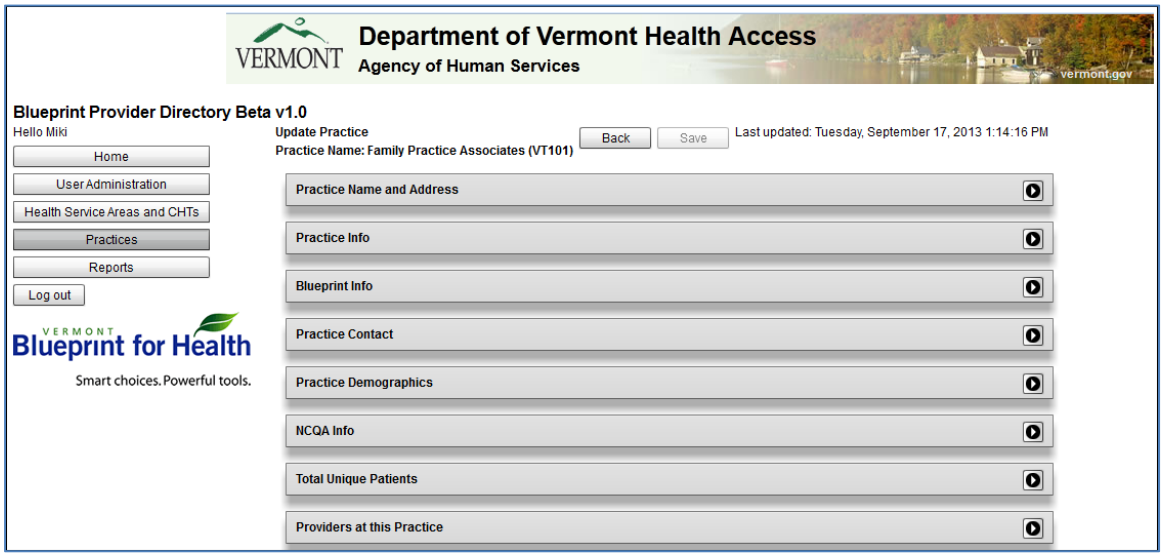
8.f. Web-based Application for Blueprint Field Team Program Information

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

With direct access to the new web application, which went Live in March 2014, Blueprint Project Managers as well as practice-level users can now enter pertinent data and also view local NCQA scoring and payment information to which they previously did not have access.

Figure 31 shows a screenshot of this new application.

Figure 31. Blueprint Field Team Program Application



9. APPENDICES

9.a. Appendix A - Budget

9.a.1. Source of Funds

Global Commitment (Blueprint and DVHA)	$ 6,446,700
HIT	$ 2,526,670
VDH ADAP FY15	$ 165,000
SIM	$ 97,278
Total Allocation	**$ 9,255,657**

9.a.2. Blueprint for Health FY15 Budget

	DVHA Blueprint Appropriation	HIT Appropriation	SIM Appropriation	VDH Appropriation	Total Blueprint Budget
Staffing	**$1,036,944**				**$1,036,944**
Operations	**$31,162**				**$31,162**
Health Service Area Grants	**$2,550,850**	**$249,000**			**$2,799,850**
Practice Facilitator Contracts	**$640,909**				**$640,909**
Other Grants and Contracts	**$1,565,935**	**$2,277,670**	**$97,278**	**$165,000**	**$4,105,883**
Statewide Registry (Covisint)		$1,276,000			$1,276,000
Hub and Spoke Collaborative (Dartmouth)				$165,000	$165,000
Network Analysis	$89,900				$89,900
Economic Modeling (Lake Champlain Capitol Management)	$105,600				$105,600
All Payers Claims Data Analysis (Onpoint)	$500,000	$500,000			$1,000,000
Blueprint Data Portal (Stone Environmental)		$161,150			$161,150
HIT Data Quality Initiative (Capitol Health Associtates)		$340,520			$340,520
Annual Blueprint Conference (UVM Medical Education)	$14,000				$14,000
NCQA Recognition (UVM VCHIP)	$530,000				$530,000
Patient Experience Survey (DataStat)	$75,000		$97,278		$172,278
Self-management Programs Support to HSAs (YMCA)	$221,435				$221,435
WRAP Training and Support (Dept of Mental Health)	$30,000				$30,000
Total Blueprint Budget	**$6,466,709**	**$2,526,670**	**$97,278**	**$165,000**	**$9,255,657**

9.b. Appendix B - Staff and Committees

9.b.1. General Contact Information

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Department of Vermont Health Access (DVHA)

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9.b.2. Blueprint Executive Committee

Craig Jones, MD, Executive Director, Blueprint for Health, Chair
Senator Claire Ayer, Vermont State Senator
Richard Boes, Department of Information and Innovation
Harry Chen, M.D., Commissioner, Vermont Department of Health
Peter Cobb, Director, Vermont Assembly of Home Health Agencies
Don Curry, President, CIGNA Health Care of New England
Tracy Dolan, Deputy Commissioner, Vermont Department of Health, Alternate
Paul Dupre, Commissioner, Vermont Department of Mental Health
Nancy Eldridge, Executive Director, Cathedral Square Corporation
Esther Emard, RN, Chief Operating Officer, NCQA
John Evans, CEO and President, Vermont Information Technology Leaders
Catherine Fulton, Executive Director, VPQHC
Andrew Garland, Vice President, Vermont/New Hampshire MVP Health Care
Don George, President and CEO, Blue Cross Blue Shield of Vermont
Bea Grause, Executive Director, VT Association of Hospitals & Health Systems
Paul Harrington, Executive Director, Vermont Medical Society
Karen Hein, MD, Member of the Green Mountain Care Board
Patrice Knapp, Director of Quality Management, VPQHC, Alternate
Mark Larson, Commissioner, Department of Vermont Health Access
Charles MacLean, MD, Professor of Medicine, Research Director AHEC Program & Office of Primary Care, University of Vermont College of Medicine
Judy Peterson, President and CEO, VNA of Chittenden and Grand Isle Counties
Thomas Peterson, Chair of Family Medicine, UVM
Darin Prail, Department of Information and Innovation, Alternate
Allan Ramsay, MD, Member of the Green Mountain Care Board
Richard Slusky, Director of Payment Reform, State of Vermont
Kara Suter, Director Payment Reform and Reimbursement, Alternate
Bill Warnock, ND, Naturopathic Physician
Susan Wehry, MD., Commissioner, Department of Disabilities, Aging & Independent Living
Robert Wheeler, MD, Blue Cross Blue Shield of Vermont, Alternate
Nicole Wilson, Assistant Director, State Employee Benefits

9.b.3. Blueprint Expansion Design and Evaluation Committee

Jean Andersson-Swayze, Independent Physician
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Pamela Biron, BCSVT
Kevin Ciechon, CIGNA
Peter Cobb, Vermont Assembly of Home Health Agencies
Regina-Anne Cooper, BCBSVT
Wendy Cornwell, Brattleboro Memorial Hospital
Audrey Fargo, VPQHC
Pamela Farnham, UVMC
Jennifer Fels, Bennington, UHA
Sharon Fine, MD, Northern Counties Health Care, Danville Health Center
Judith Franz, VITL
Aaron French, Department of Vermont Health Access
Scott Frey, BCBSVT
Cathy Fulton, VPQHC
Eileen Girling, Department of Vermont Health Access
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Carolyn Goodwin, Rutland Regional Medical Center
Paul Harrington, Vermont Medical Society
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Jenney Samuelson, Vermont Blueprint for Health
Marietta Scholten, MD, APS Health Care
Connie Schutz, Department of Vermont Health Access
Judith Shaw, University of Vermont
Kate Simmons, Bi-State Primary Care Association
Richard Slusky, Director of Payment Reform, GMCB
Kelly Smith, BCBSVT
Audrey Spence, BCBSVT
Beth Tanzman, Vermont Blueprint for Health
Richard Terricciano, Vermont Blueprint for Health
Robert Wheeler, BCBSVT
Sharon Winn, Bi-State
Mark Young, Central Vermont Medical Center

9.b.4. Blueprint Payment Implementation Work Group

Deborah Andrews, Fletcher Allen Health Care
Gail Auclair, Little Rivers
Sherry Bellimer, Mount Ascutney Hospital and Medical Center
Pamela Biron, Blue Cross Blue Shield Vermont
David Brace, Community Health Services of Lamoille Valley
Susan Cartwright, Vermont Blueprint for Health
Kaylie Chaffee, Springfield Medical Center
Kevin Ciechon, CIGNA
Ann Collins, CIGNA
Candace Collins, Northwestern Medical Center
Lori Collins, Department of Vermont Health Access, State of Vermont
Wendy Cornwell, Brattleboro Memorial Hospital
Jean Cotner, Porter Medical Center
Carol Cowan, Blue Cross Blue Shield Vermont
Fiona Daigle, Fletcher Allen Health Care
Amy Dobson, Burlington
Jennifer Fels, United Health Alliance
Betsy Field, Independent Practice Manager, Morrisville HSA
Christine Fortin, Northern County Hospital
Scott Frey, Blue Cross Blue Shield Vermont
Marie Gilmond, Rutland Medical Center
Roberta Gilmour, Fletcher Allen Health Care
Jacqueline Graham, Hewlett-Packard Company
Susan Gretkowski, MVP Health Care
Marcie Hawkins, CIGNA
Miki Hazard, Vermont Blueprint for Health
Penrose Jackson, Fletcher Allen Health Care
Craig Jones, Vermont Blueprint for Health
Pat Knapp, Springfield Medical Center
Michael Landon, Gifford Medical Center
Kelly Lange, Blue Cross Blue Shield
Jill Lord, Mount Ascutney Hospital & Medical Center
Wendy Macfarlane, Burlington
James Mauro, Blue Cross Blue Shield Vermont
Elise McKenna, Morrisville
Gail McKenzie, Mount Ascutney Hospital & Medical Center
Lou McLaren, MVP Health Care
Susan Monica, Little Rivers
Sarah Narkewicz, Rutland Regional Medical Center
Michelle Patterson, Porter Medical Center
Tracey Paul, North Country Hospital
Rita Pellerin, Fletcher Allen Health Care
Suzanne Peterson, Porter Medical Center

Blueprint Payment Implementation Work Group (continued)

Allan Ramsay, MD, Green Mountain Care Board
Jack Reilly, Mount Ascutney Hospital & Medical Center
Julie Riffon, North Country Hospital Center
Jeffrey Ross, Department of Vermont Health Access, State of Vermont
Laural Ruggles, Northeastern Regional Hospital
Jenney Samuelson, Vermont Blueprint for Health
Robyn Skiff, Fletcher Allen Health Care
Richard Slusky, Director Health Care Reform, Green Mountain Care Board
Beth Tanzman, Vermont Blueprint for Health
Tim Tremblay, Vermont Blueprint for Health
Lynn Trepanier, Blue Cross Blue Shield Vermont
Robert Wheeler, Blue Cross Blue Shield Vermont
Mark Young, Central Vermont Medical Center

9.b.5. Mental Health & Substance Abuse Advisory Committee

Peter Albert, LICSW, Senior VP Government Relations & PrimariLink Retreat Health Care
Mark Ames, Network Coordinator, Vermont Recovery Network
Susan Atwell-Hall, Blue Cross Blue Shield Vermont
Ena Backus, Green Mountain Care Board, Staff
Rick Barnett, Psy.D., LADC, President, Vermont Psychological Association
Wendy Beinner, Executive Director, NAMI-VT
Bob Bick, Director of Mental Health and Substance Abuse Services, Howard Center for Human Services
Charles Biss, MSW, Director Child & Family Services, Vermont Department of Mental Health
Steve Broer, Northwestern Counseling Service, Mental Health Operations Director
Barbara Cimaglio, Deputy Commissioner, Vermont Department of Health Alcohol & Drug Abuse Programs
Candace Collins, Franklin County Health Service Area, Blueprint Project Manager
Jackie Corbally, MSW, Chief of Treatment, Vermont Department of Health Alcohol & Drug Abuse Programs
Linda Corey, Executive Director, Vermont Psychiatric Survivors
Anne Donahue, BA, JD, Vermont Legislative Representative, Co-Chair Mental Health Oversight Committee
Paul Dupre, Commissioner, Vermont Department of Mental Health
Will Eberle, Executive Director, Another Way
Peter Espenshade, Executive Director VAMHAR
Pam Farnham, CHT Leader, University of Vermont Medical Center
David Fassler, MD, President Vermont Association of Child & Adolescent Psychiatry, Council of Mental Health and Substance Abuse Professionals
Caryn Feinberg, Vt. Mental Health Counselors Association
Jennifer Fels, Blueprint Project Manager, Bennington
Betsy Fowler, LICSW, LADC, Lead Behavioral Health Specialist, Northeastern Vermont Regional Hospital
Gordon Frankle, MD, Rutland Regional Medical Center
Kathy Holsopple, Executive Director, Vermont Federation for Families
Penrose Jackson, Fletcher Allen Health Care, Community Improvement
Craig Jones, MD, Executive Director, Vermont Blueprint for Health
Rodger Kessler, PhD, ABPP, Coordinator, Primary Care Behavioral Health, Fletcher Allen Patient Centered Medical Home
Marcia LaPlante, Vermont Department of Health, Substance Abuse Prevention
Jill Lord, RN, MS, Director Patient Care Services, Mt Ascutney Hospital and Health Center
John Meyer, Shelburne Psychological Counseling Services
Gail Middlebrook, Substance Abuse Services Director, Northeast Kingdom Human Services
Melissa Miles, MPH Project Managers Bi-State Primary Care Association
Clare Munat, Alternating Co-Chair, State Program Standing Committee for Adult Mental Health
Sarah Narkewicz, Blueprint Project Manager, Rutland Region Health Service Area
Nick Nichols, Director of Policy, Vermont Department of Mental Health

Mental Health & Substance Abuse Advisory Committee (continued)

Eilis O'Herlihy, Executive Director, National Association of Social Workers, VT Chapter
Ralph Provenza, Executive Director, United Counseling Services
Simone Rueschemyer, Director Behavioral Health Network
Alice Hershey Silverman, MD, President Vermont Psychiatric Association
Beth Tanzman, Assistant Director, Vermont Blueprint for Health
Julie Tessler, Executive Director, Vermont Council Developmental & Mental Health Services
Diane Tetrault, MA, LCMHC, Legislative Chair, Vermont Mental Health Counselors Association
Gloria van den Berg, Executive Director, Alyssum, Inc.
Susan Walker, President, Vermont Recovery Network
Jim Walsh, PMH-NP, BC, Co-Director, Windham Center Psychiatric Services Health Center at Bellows Falls

9.c. Appendix C - Partnerships with National Initiatives

Centers for Medicare and Medicaid Services (CMS)

Vermont is one of 8 states chosen to be part of the Multi-payer Advanced Primary Care Practice (MAPCP) Demonstration through the Center for Medicare and Medicaid Innovation (CMMI). For more information, refer to (http://www.cms.gov/DemoProjectsEvalRpts/MD/ItemDetail.asp?ItemID=CMS1230016). This opportunity includes Medicare into the Blueprint multi-payer payment reforms as a fully participating insurer. In 2014, CCMI extend the MAPCP Demonstration in Vermont for an additional 2.5 years, through December 2016.

Institute of Medicine of the National Academies (IOM)

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

National Academy of State Health Policy (NASHP)

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

9.d. Appendix D - Presentations and Meetings

OUT OF STATE MEETINGS			
1/15/14-1/16/14	Oregon Primary Care Association - Oregon Models of Care	Oregon	C. Jones
1/23/2014	Presentation at the Nat'l Families USA "Health Action 2014 Conference" on Innovations in Medicaid: Payment Delivery Reform	Washington, DC	B. Tanzman
1/30/14-1/31/14	2014 Wagner Endowment Symposium: "Primary Care Health Extension Programs: Current Models and Future Directions." -Keynote Speaker	Seattle, WA	C. Jones
2/7/2014	NASHP - Federal State Discourse on Shared Resources to Sustain Primary Care Transformation - Speaker	Washington, DC	C. Jones
2/27/2014	Care Innovation Summit 2014 (Aspen Institute & Advisory Board Company) - Speaker	Washington, DC	C. Jones
3/5/2014	IOM Consensus Committee on Core Metrics	Washinton, DC	C. Jones
4/3/14 - 4/4/14	Milbank Multi State Meeting	Portland, ME	C. Jones
4/7/14 - 4/8/14	University of Delaware Health Care Symposium	Newark, Delaware	C. Jones
4/30/2014	Total Population Health Technical Expert Panel	Washington, DC	C. Jones
5/2/2014	Pediatric Academic Societies	Washington, DC	C. Jones
6/12/14 - 6/13/14	Population Health Conference	Boston, MA	C. Jones
6/26/14 - 6/27/14	IOM Meeting on Core Metrics	Washington, DC	C. Jones
7/10/14 - 7/11/2014	CIPCI St. Francis Care Roundtable Meeting	Hartford, CT	C. Jones
9/9/2014	Academy of Managed Care Pharmacy- Best Practices for ID and Treatment of Opioid Dependence	Alexandria, VA	B. Tanzman
9/11/14 - 9/12/14	RWJF International Meeting on Primary Care	London England	C. Jones
10/3/2014	Maine Quality Counts	Manchester, ME	J. Samuelson
10/8/2014	NASHP	Atlanta, GA	J. Samuelson

IN STATE MEETINGS			
1/10/2014	Presentation to the Vermont Statewide Pyschiatric Nurse Practitioners Group "Health Reform and the Blueprint for Health"	Burlington, VT	B. Tanzman
1/15/2014	Blueprint/VITL Data Quality and Connectivity Program - Porter Medical Center	Middlebury, VT	M. Olszewski
1/24/2014	Department of Vermont Health Access - Blueprint Evaluation Presentation	Williston, VT	C. Jones
1/27/2014	Blueprint Pay for Performance Model - Physicians Group Gifford Medical Center	Springfield, VT	C. Jones
2/3/2014	Blueprint Pay for Performance Model - Physicians Group Northwestern Medical Center	St. Albans, VT	C. Jones
2/4/2014	Blueprint Pay for Performance Model - Physicians Group	Bennington, VT	C. Jones
2/5/2014	Vermont Legislative House Health Committee / Senate Health & Welfare/ House Appropriations Committee Mtgs. - Blueprint Presentation	Montpelier, VT	C. Jones
2/10/2014	Covisint DocSite Program Functionality Feedback Sessions - Rutland CHT	Rutland, VT	M. Olszewski
2/11/2014	Covisint DocSite Program Functionality Feedback Sessions - Cathedral Square (SASH), Burlington	Burlington, VT	M. Olszewski
2/10/2014	Blueprint Pay for Performance Model - Physicians Group Burlington Health Service Area	Burlington, VT	C. Jones
2/12/2014	Blueprint/VITL Data Quality and Connectivity Program - Richmond Family Practice	Richmond, VT	M. Olszewski
2/12/2014	Testimony Vermont House Health Care Committee "Adverse Childhood Experiences Screening and Trauma Informed Services"	Montpelier, VT	B. Tanzman
2/13/2014	Blueprint Pay for Performance Model - Physicians St. Johnsbury Health Service Area	St. Johnsbury, VT	C. Jones
2/18/2014	Presentation to the Vermont Care Models & Care Management Work Group "Hub & Spoke and Care Management"	Williston, VT	B. Tanzman
2/19/2014	House Ways & Means Committee - Blueprint Presentation	Montpelier, VT	C. Jones
2/21/2014	Blueprint Presentation to the Green Mountain Care Board	Montpelier, VT	C. Jones

IN STATE MEETINGS			
2/24/2014	Blueprint Pay for Performance Model - Physicians Brattleboro Health Service Area	Brattleboro, VT	C. Jones
2/24/2014	Presentation to the Family Medicine Grand Rounds of Fletcher Allen Health Care "Hub & Spoke System and Family Medicine"	Burlington, VT	B. Tanzman
2/25/2014	Blueprint Pay for Performance Model - Physicians Rutland Health Service Area	Brattleboro, VT	C. Jones
2/26/2014	Testimony to the Vermont House Health Care Committee "Planning for a Trauma Treatment Services"	Montpelier, VT	B. Tanzman
2/26/2014	Testimony to the Senate Health and Welfare Committee "Screening, Court Diversion and Referral to Addictions Treatment Services"	Montpeliler, VT	B. Tanzman
3/11/2014	Delivered Blueprint Presentation with Congressman Welch	Colchester, VT	C. Jones
3/11/2014	Blueprint Pay for Performance Model - Morrisville Health Service Area	Morrisville, VT	C. Jones
3/12/2014	Blueprint Presentation to the SIM Workforce Group	Montpelier, VT	C. Jones
3/13/2014	Blueprint Presentation to the Green Mountain Care Board	Montpelier, VT	C. Jones
3/20/2014	Blueprint Presentation - University of Vermont School of Medicine Health Policy Workshop	Burlington, VT	C. Jones
3/20/2014	NASHP National Audience Webinar - Quality Measurement to Support Value-Based Purchasing: Aligning Federal & State Efforts	Webinar	J. Samuelson
3/20/2014	Presentation to the Green Mountain Care Board "Hub & Spoke System of Care: Opportunities and Challenges"	Montpelier, VT	B. Tanzman
3/28/2014	Blueprint/VITL Data Quality and Connectivity Program - Charlotte Family Practice	Charlotte, VT	M. Olszewski
3/31/2014	Blueprint Pay for Performance Model - Hardwick Health Service Area	Hardwick, VT	C. Jones
4/9/2014	Blueprint for Health Annual Meeting - Presentation on Practice Profiles: Using Data to Drive Change	Burlington, VT	C. Jones
4/15/2014	FQHC Medical Directors Meeting	Montpelier, Vt	C. Jones
4/16/2014	Pay for Performance Presentation to Middlebury Providers	Middlebury, VT	C. Jones
4/28/2014	Pay for Performance Presentation to BCBS	Barre, VT	C. Jones

IN STATE MEETINGS			
5/8/2014	Pay for Performance Presentation to Barre Providers	Barre, VT	C. Jones
5/12/2014	Bi-State Primary Care Association	Fairlee, VT	C. Jones
4/4/2014	Data Quality and Connectivity Payment Program Presentation to Alderbrook Family Health	Essex Jct, VT	M. Olszewski
7/22/2014	Housing Plus Services Learning Collaborative	Burlington, VT	C. Jones
9/9/2014	VITL Annual Summit Meeting	South Burlington, VT	J. Samuelson
9/10/2014	MAPCP All State Meeting	Webinar	J. Samuelson
7/8/2014	Vermont Blueprint: Sharing Vermont Blueprint's effectiveness with the Pennsylvania MAPCP steering committee	Webinar	J. Samuelson
7/9/2014	Vermont BP for Health Workforce of Today and Future Needs	Montpelier, VT	B. Tanzman
7/17/2014	Peer Recovery Services Meeting	Burlington, VT	B. Tanzman
8/26/2014	*VT Dept. of Voc-Rehab and Dept. of Mental Health- Reenergizing Supported Employment Services for Community Rehab and Treatment*	Waterbury, VT	B. Tanzman
8/28/2014	Child and Family Trauma Workgroup	Waterbury, VT	B. Tanzman
9/30/2014	National Academy for State Health Policy- Sustaining PCMH	Webinar	B. Tanzman