

****THIS TESTIMONY IS EMBARGOED UNTIL 2:00
PM MAY 12, 2011****

VERMONT BLUEPRINT BACKGROUND AND HISTORY

Legislation

The Douglas Administration formally launched the Vermont Blueprint in 2003. The goal at the time was to address the increasing costs of caring for people with chronic illnesses, with an early emphasis on diabetes management in response to the overwhelming projected burden of morbidity and resource utilization. The transition to a more broadly defined Health Reform agent of change has occurred over time. Throughout the Blueprint's history, the Legislative and Executive branches have been critical in its support and development as follows:

- **2006** – The Blueprint officially became law when the Vermont Legislature passed Act 191, sweeping Health Care Reform that also created Catamount Health to provide coverage to uninsured Vermonters. The Act included language that officially endorsed the Blueprint and expanded its scope and scale.
- **2007** -- The Legislature further defined the infrastructure for administering the Blueprint with Act 71 and mandated “integrated” pilot projects to test the best methods for delivering chronic care to patients -- based on the Patient Centered Medical Home model and multi-disciplinary locally-based care coordination teams (Community Health Teams). The original pilot sites were chosen through competitive request for proposals processes in 2007 and 2008 from communities that had been actively involved in Blueprint quality improvement initiatives. Voluntary payment reform to support these innovations in health care delivery was introduced. This transition ultimately led to the Advanced Primary Care Practice model now being implemented statewide.
- **2008** -- Act 204 further defined the Integrated Pilots and officially required insurer participation in their financial support, which covered approximately 10 percent of the state population.
- **2009** – Launch of the Vermont Accountable Care Organization Pilot (ACO) -- A project led by the Vermont Health Care Reform Commission (HCRC) to investigate how ACOs might be incorporated into the state's comprehensive health reform program.
- **2010** – Act 128 updates the definition of the Blueprint for Health 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.” It also requires the Commissioner of the Department of Vermont Health Access to expand the Blueprint for Health to at least two primary care practices in every hospital services area no later than July 1, 2011, and no later than October 1, 2013, to all primary care practices statewide that wish to participate.

See <http://hcr.vermont.gov/legislation> for more detail on specific legislation.

Blueprint Integrated Health Service Program and Advanced Primary Care Practice

The Advanced Primary Care Practice model (the basis for the original Blueprint Integrated Pilots and subsequent expansion to the Integrated Health Service program) is characterized by seamless coordination of care. It stresses the importance of preventive health – engaging people when they are well, as well as giving patients the tools to keep existing conditions from worsening. Patients are encouraged to become active partners in their own care, and practices become effective and efficient teams.

As one of the requirements of recognition as a Blueprint IHS ACP, practices must meet a set of criteria for Patient Centered Medical Homes, established by the National Committee for Quality Assurance (NCQA), a non-profit organization dedicated to improving health care quality. Per the 2007 Joint Statement from the American Academy of Pediatrics, the American Academy of Family Physicians, the American College of Physicians and the American Osteopathic Association, a “Patient Centered Medical Home is an approach to providing comprehensive primary care for children, youth and adults. The PCMH is a health care setting that facilitates partnerships between individual patients and their personal physician and, when appropriate the patients’ families.” (See <http://www.pcpcc.net/content/joint-principles-patient-centered-medical-home>).

The PCMH philosophy is that the delivery of health care is analogous to a “team sport”. The following are some basic principles:

1. Patients identify and get access to their primary care team as their first contact for a new or ongoing health care concern. While the primary care provider directs the team, appropriate access is enhanced.
2. The practice routinely acts from a whole person and patient centered orientation. The scope of primary care is not just bio-medical care, but also the creation of a continuous healing relationship that address multiple dimensions of care (psycho-social) and social realities and concerns. Individual care plans are responsive to patient preferences and reflect up-to-date evidence-based guidelines.
3. Attention is paid to population health outcomes. The goal is to affect a whole population, and not just segments of it.
4. Care is coordinated and integrated, linking the practice-based activities with multiple external providers. This takes human resources, time, and the establishment of relationships – supported by technology for tracking, communication and decision making.
5. The PCMH practice demonstrates capacity for continuous learning and practice improvement. Emphasis is placed upon quality improvement both of internal practice

processes (electronic medical record implementation, scheduling for increased access, prescription filling, and laboratory test and imaging results) and evaluation and measurement of individual and group outcomes.

6. The practice is committed to achievement of the “Triple Aim”: improving patient experience of care, improving health outcomes for the population, and “bending” the cost curve.

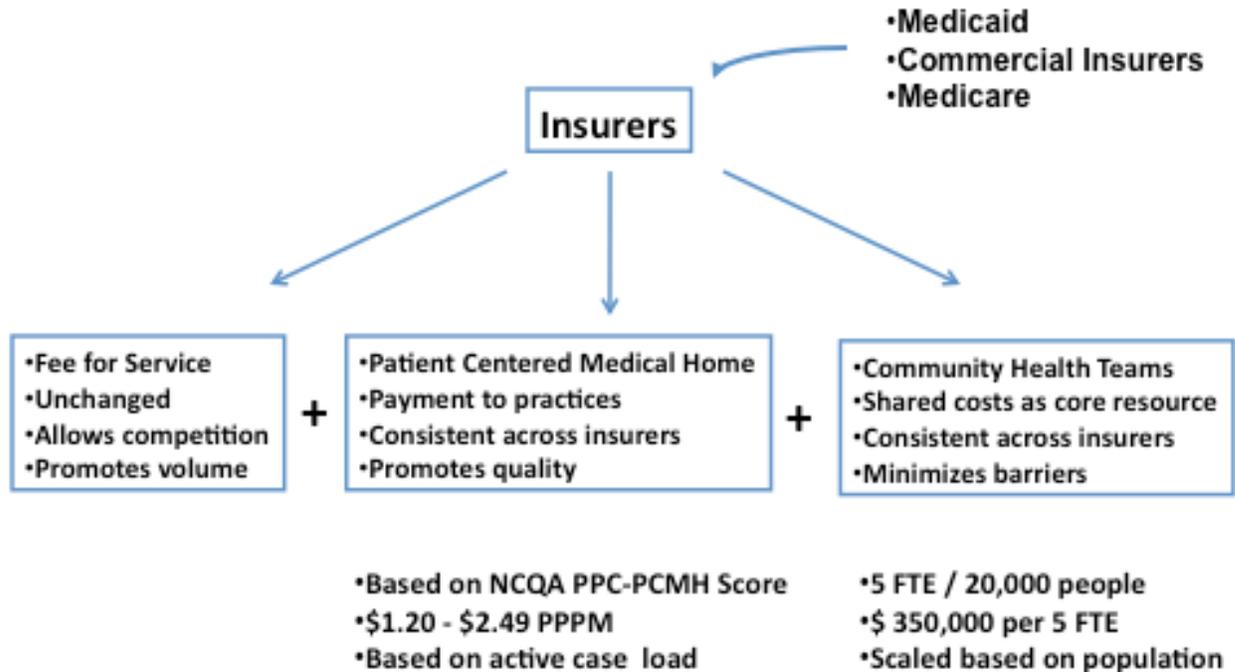
Using the NCQA Physician Practice Connection – Patient Centered Medical Home (PPC-PCMH) recognition rubric, practices are scored on their compliance with standards related to areas such as access and communication, patient tracking and registry functions and advanced electronic communications. These evolved practices create internal teams, maximizing the effectiveness of their staff and expanding the definition of their roles within the site and beyond.

See <http://www.ncqa.org/tabid/631/Default.aspx> for a full description of the NCQA PPC-PCMH standards.

Payment Reform

Figure 1. Payment Reform Schematic Diagram

Multi-insurer Payment Reforms



Vermont’s Integrated Health System APCP model includes two components of payment reform, which are applied consistently to all participating public and commercial insurers. Currently, fee-for-service methodology remains intact, with the reforms below in addition.

1. *Enhanced Payments to Advanced Primary Care Practices*
 All insurers pay each recognized APCP an enhanced provider payment above the existing fee-for-service payments – calculated on a per patient per month (PPM) basis – and based on the quality of the health care they provide as defined by the NCQA PPC-PCMH standards. In order to calculate payment, each insurer must count the number of their beneficiaries that are attributed to a practice, and multiply that by the PPM amount.

2. *Community Health Team Payments*
 The Vermont Blueprint emphasizes that the excellent and challenging work of an APCP must be supported by more than just the NCQA PPC-PCMH-triggered payments. A dedicated Community Health Team (CHT) provides this essential

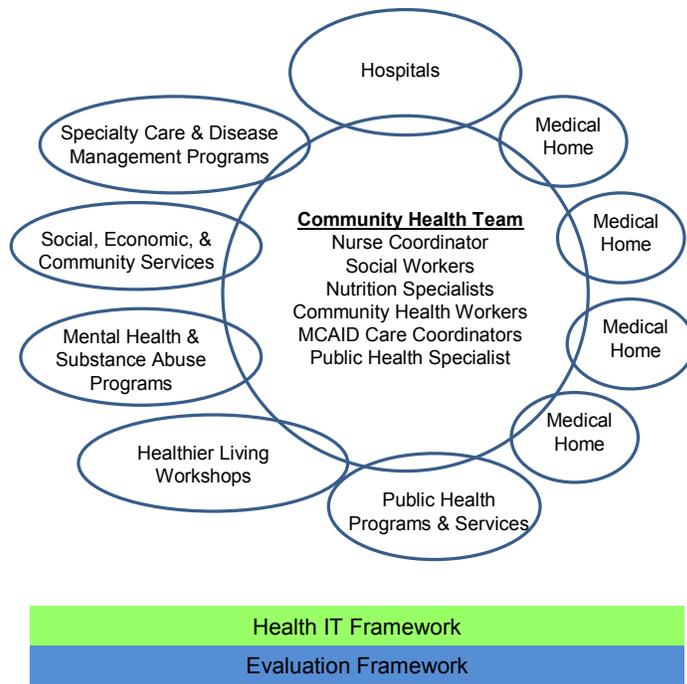
range of services. Insurers currently share the costs of CHTs equally. This support allows the services of a CHT to be offered free of charge to patients and practices, with no co-pay or prior authorization. Insurers provide a total of \$350,000 per full CHT annually, which serves a general population of 20,000, with shares paid to a single existing administrative entity in each HSA. This combined funding covers the salaries of the core team, allowing for barrier-free access to the essential services provided. While this “core” CHT often works one-on-one with patients to meet a wide range of needs, the “functional” team may be much larger, including members of other local individuals and organizations who work in partnership with the CHT and the APCP.

Planning and refining these elements are achieved through consensus in the Blueprint Expansion Design and Evaluation Committee, and the details of implementation at the Blueprint Payment Implementation Work Group. Both groups are well represented by a wide variety of stakeholders and serve to advise the Blueprint Executive Director.

Community Health Teams

The Blueprint’s cutting edge payment reforms allow for the innovative Community Health Teams (CHTs) to provide services free of charge to the APCP patients. The multidisciplinary CHT partners with primary care offices, the hospital, and existing health and social service organizations. (Please see Figure 2.) The goal is to provide Vermonters with the support they need for well-coordinated preventive health services, and coordinated linkages to available social and economic support services. The CHT is flexible in staffing, design, scheduling and site of operation, resulting in a cost-effective, core community resource which minimizes barriers and provides the individualized support that patients need in their efforts to live as fully and productively as possible. The CHTs function as extenders of the practices they support, and their services are available to all patients (no eligibility requirements, prior authorizations or co-pays).

Figure 2. Community Health Team Schematic Diagram

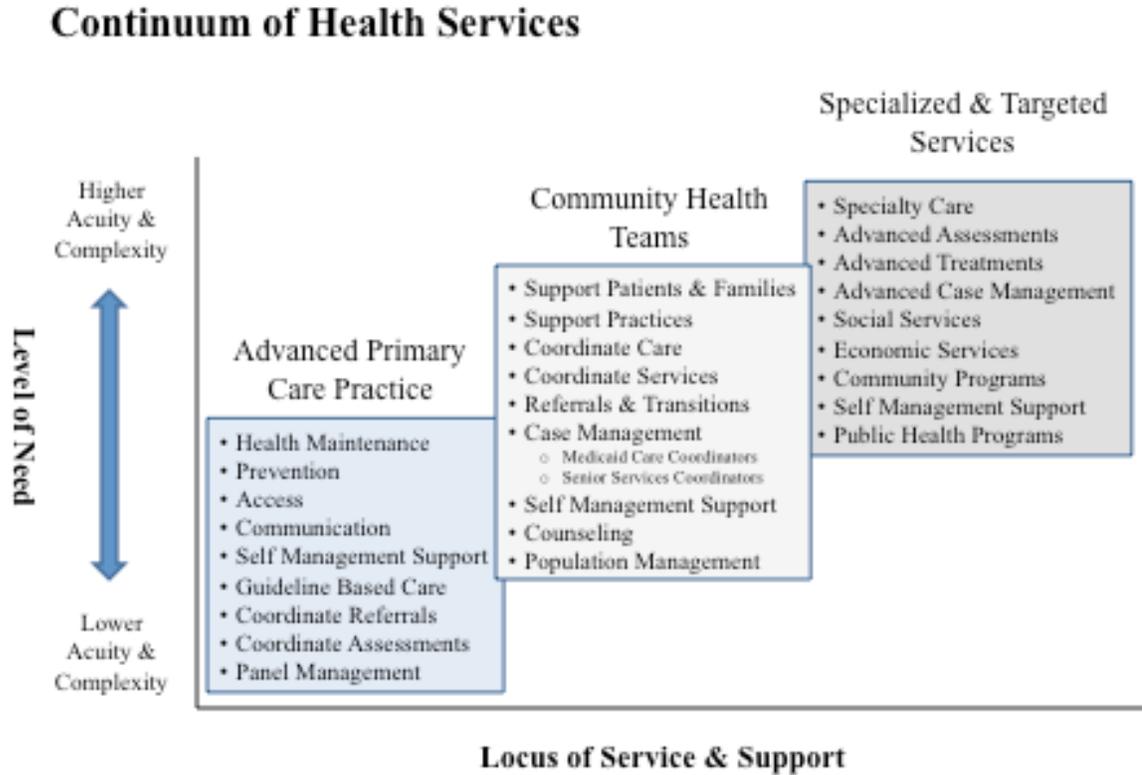


To ascertain the local Health Service Area’s specific needs, the local IHS workgroup identifies current health services and existing gaps for patients and providers in participating primary care practices and the surrounding community. Based on the information obtained, the group will build the foundation of the CHT by working together to determine how existing services can be reorganized and what new services are required.

The overall design of the Blueprint Integrated Health Services model provides patients with seamless and well-coordinated health and human services. This includes transitioning patients from patterns of acute episodic care to preventive health services. Well structured follow up and coordination of services after hospital based care has been shown to improve health outcomes and reduce the rate of future hospital based care for a variety of patient groups and chronic health conditions (e.g. reduce emergency department visits, hospital inpatient admissions, re-admissions). CHT members, hospital staff, and other community service providers work closely together to implement transitional care strategies that keep patients engaged in preventive health practices and improved self-management. A goal of the Blueprint model is seamless coordination across the broad range of health and human services (medical and non-medical) that are essential to optimize patient experience, engagement, and to improve the long term health status of the population.

The Community Health Team serves as the central locus of coordination and support for patients. The spectrum of services from those appropriate for the general population to those targeted to subgroups with specific needs is illustrated in Figure 3, below.

Figure 3. Spectrum of Health and Health-Related Services



Expansion and Quality Improvement Program (EQuIP)

The scope and scale of primary care practice transformation requires extraordinary support. In addition to the enhanced financial components of the Blueprint’s payment reforms, the individual primary care sites are working with highly skilled practice

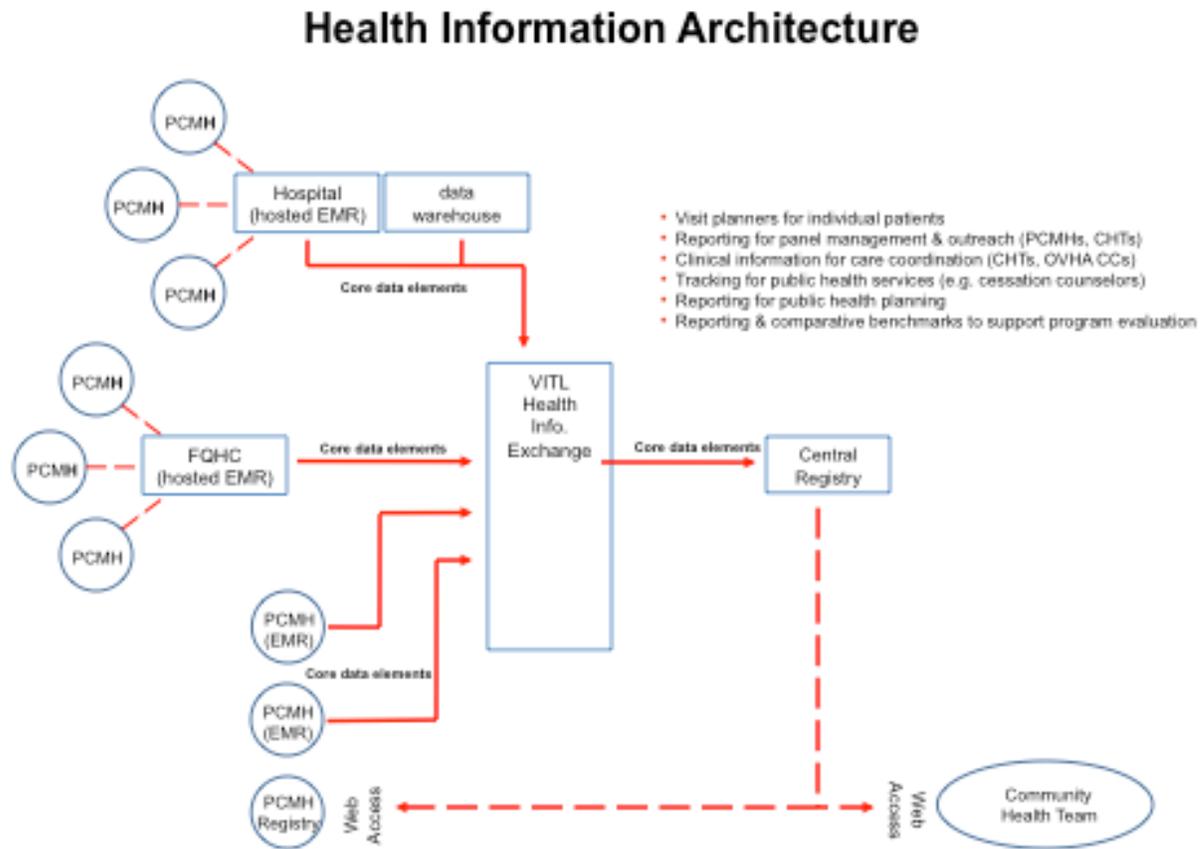
facilitators through the statewide Expansion and Quality Improvement Program (EQuIP). These individuals, funded by the state, work with 9-15 primary care practices on process improvement, clinical projects and team building. While a great deal of emphasis is currently on preparation for recognition as a patient centered medical home by NCQA, their work continues far beyond that in a continuous quality improvement cycle.

Health Information Architecture

The Blueprint works closely with the Vermont Information Technology Leaders (VITL) – the state-sponsored Health Information Exchange (HIE) – to develop infrastructure that supports the meaningful use of health information. The core of this infrastructure is the Blueprint’s centralized registry and web-based clinical tracking system: DocSite-Covisint. The registry is used to produce visit planners that guide individual patient care, and to produce reports that support population management, quality improvement, program evaluation and comparative benchmarking.

Data from the IHS APCP sites are sent to DocSite from the point of care, either entered manually into the web-based portal or via interfaces with electronic medical records and direct feeds from labs and hospitals. It is a major goal to facilitate the entry of data at the point of care while minimizing any disruptions to the work flow of the practice. This is a major improvement process and effort at the practice level, facilitated by the EQuIP and internal practice teams. All aspects of the Blueprint’s information architecture are designed to meet strict guidelines concerning data access and privacy protections.

Figure 3. Blueprint Health Information Technology Architecture



Evaluation Infrastructure

The Blueprint has established a multi-faceted assessment process to support evaluation and ongoing refinement of a complex transformation process. Where possible, evaluation and reporting build on Vermont’s steadily growing health information infrastructure with centralized clinical and administrative data sources that are populated as part of the normal daily activities of health service providers. Web based flexible reporting is being instituted to make best use of these centralized data sources in a way that supports rapid cycle evaluation. In addition, supplemental research activities are required to more fully understand the impact of the program, particularly the human and societal impacts that may not be readily determined with structured clinical and administrative data captured as part of routine operations. The major components and current status of the Blueprint evaluation program are summarized below (Table 1).

Table 1. Evaluation infrastructure

Data Sources	Databases	Measures	Reporting	Status
Data feeds from EMRs and Hospitals through Vermont Information Technology Leaders (VITL) health information exchange network. Direct use of registry as health services tracking system by practices and other service providers	Web based central clinical registry. Developed and hosted by Covisint - DocSite.	<ul style="list-style-type: none"> ▪ Clinical Processes ▪ Health Status ▪ Performance ▪ Comparative Effectiveness 	<ul style="list-style-type: none"> ▪ Web based flexible reporting by registry system ▪ Feeds to University of Vermont (UVM) Informatics Platform 	<ul style="list-style-type: none"> ▪ Active data transmission and reporting ▪ Expand interfaces and data transmission in collaboration with VITL as Blueprint expands statewide
Data feeds (demographic & paid claims data) from insurers. Common format allowing integration into single data base	Multi-payer claims database. Developed and hosted by Onpoint Health Data.	<ul style="list-style-type: none"> ▪ Healthcare Patterns ▪ Resource Utilization ▪ Healthcare Expenditures ▪ Performance ▪ Comparative Effectiveness 	<ul style="list-style-type: none"> ▪ Analysis & standard reports generated by Onpoint Health Data ▪ Includes detailed evaluation of utilization & costs for patients treated in Blueprint model with comparison cohorts. ▪ Feeds to UVM Informatics Platform 	<ul style="list-style-type: none"> ▪ Complete data sets from all commercial insurers. ▪ Vermont Medicaid implementing data transmission ▪ Work beginning with CMS to get Medicare data sets
Data sets from hospital, practice, and insurer administrative data systems. Supplied by Information Technology staff at hospitals for hospital affiliated practices	Data sets maintained and analyzed by Jeffords Institute at Fletcher Allen Health Care	<ul style="list-style-type: none"> ▪ Emergency Room Visits ▪ Hospital Admissions ▪ Utilization rates as affiliated practices transition to Blueprint model 	<ul style="list-style-type: none"> ▪ Analysis & standards reports generated by Jeffords Institute at Fletcher Allen Health Care. ▪ Includes trends over time in hospital based care for patients treated in Blueprint model 	<ul style="list-style-type: none"> ▪ Data and early trends available for hospital affiliated practices available from Blueprint pilot communities ▪ Medicaid preparing data set across communities
Structured chart reviews in primary care practices conducted by Vermont Child Health Improvement Program (VCHIP) based at the University of Vermont (UVM)	Chart review data set maintained and analyzed by VCHIP at UVM	<ul style="list-style-type: none"> ▪ Clinical Processes ▪ Health Status ▪ Performance ▪ Comparative Effectiveness 	<ul style="list-style-type: none"> ▪ Analysis and standard reports generated by VCHIP / UVM ▪ Includes analysis of healthcare quality and health outcomes, trends over time 	<ul style="list-style-type: none"> ▪ ~ 4500 charts reviewed annually. ▪ ~ 3 years of data available thru CY 2009 ▪ Early trends available for pilot and comparison communities
Structured scoring of practices based on National Committee on Quality Assurance Physician Practice Connections-Patient Centered Medical Home (NCQA PPC-PCMH) standards conducted by VCHIP at UVM	NCQA PPC-PCMH scoring data set maintained and analyzed by VCHIP at UVM	<ul style="list-style-type: none"> ▪ Clinical Processes ▪ PCMH Standards 	<ul style="list-style-type: none"> ▪ Analysis & standard reports generated by VCHIP at UVM ▪ Includes analysis of the relationship between NCQA PPC-PCMH standards, clinical quality, and health status measures from chart review 	<ul style="list-style-type: none"> ▪ Baseline NCQA PPC-PCMH Scoring available for practices in pilot communities. and in near term expansion communities ▪ Repeat scoring available in select practices

Data Sources	Databases	Measures	Reporting	Status
Structured qualitative assessments using focus groups and interviews addressing the experience of practice based providers, community health team members, and patients. Conducted by VCHIP/UVM.	Qualitative assessment data maintained and analyzed by VCHIP/ UVM	<ul style="list-style-type: none"> ▪ Consistent trends and key findings based on the experience of practice based providers, community health team members, patients. ▪ Strengths, challenges, recommendations for improvement 	<ul style="list-style-type: none"> ▪ Analysis & standard report generated by VCHIP/UVM 	<ul style="list-style-type: none"> ▪ Early findings available for Blueprint pilot communities and one comparison community
Hospital Discharge data through Vermont Department of Banking, Insurance, Healthcare Administration (BISHCA). Behavioral Risk Factor survey data, and Youth Risk Factor survey data generated by Vermont Department of Health (VDH)	Public Health Registries maintained and analyzed by VDH Epidemiology & Statistics Section.	<ul style="list-style-type: none"> ▪ Rates of hospital admissions, emergency care, procedures, associated charges, demographic risk factors, social risk factors, economic risk factors, behavioral risk factors, clinical risk factors 	<ul style="list-style-type: none"> ▪ Analysis & standard reports generated by the VDH Statistics Section ▪ Includes mapping and trends over time for multiple variables related to chronic conditions 	<ul style="list-style-type: none"> ▪ Report available that includes 10 year trends in Vermont ▪ Useful for planning health services strategies and tracking change over time at a population level
Data feeds from multi-payer claims database (Onpoint) and central clinical registry (Covisint DocSite) currently planned. Potential for other data sources (e.g. public health registries)	Integration of data and merged database maintained by Center for Translational Sciences at UVM	<ul style="list-style-type: none"> ▪ Clinical process ▪ Health status ▪ Utilization ▪ Expenditures ▪ Predictive modeling 	<ul style="list-style-type: none"> ▪ Web based flexible reporting from novel statewide integrated informatics platform (e.g. merged clinical, utilization, and expenditure data) ▪ Data sets for advanced analytics 	<ul style="list-style-type: none"> ▪ Informatics platform under development at UVM ▪ Data sharing agreements being prepared for multi-payer claims data and central clinical registry data

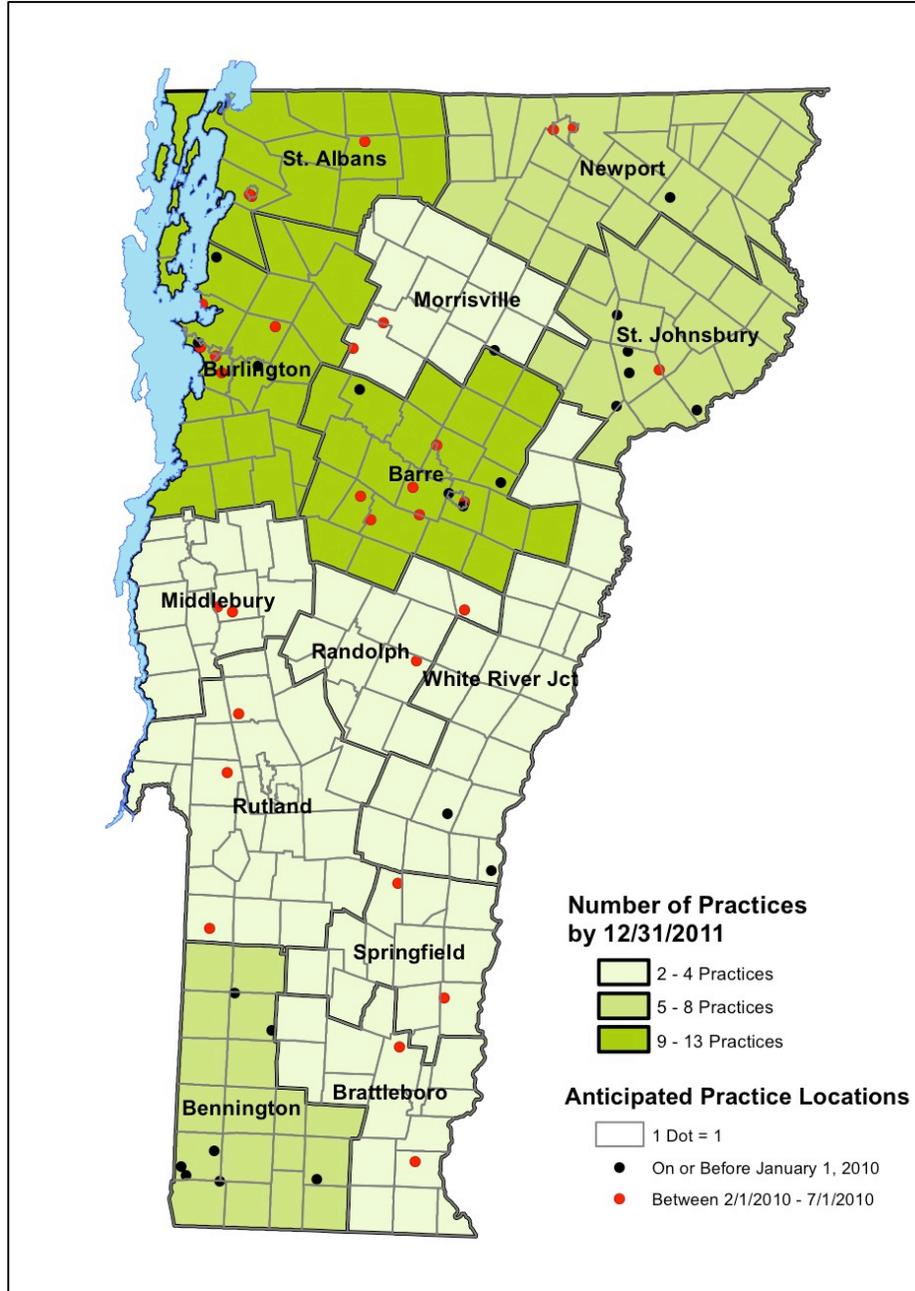
Early trends are pointing towards decreases in utilization of expensive services such as emergency room visits and inpatient admissions in the initial pilot sites. Further collection and analysis of data will more clearly indicate the efficacy of the program. For more information, please see the *Vermont Blueprint for Health 2010 Annual Report to the Legislature* at the following link:

http://hcr.vermont.gov/sites/hcr/files/final_annual_report_01_26_11.pdf

Please see the Financial Impact model in Appendix I for “Return on Investment” information.

Figure 4. Statewide Blueprint Expansion

Blueprint Expansion: Anticipated Advanced Primary Care Practices (January 2011 through January 2012)



Date: 1/14/2011

Blueprint expansion is mandated in legislation, and is currently on track to achieve the milestones articulated for July 1, 2011. The statewide network of project managers at the Health Service Area level is responsible for this complex process following the steps outlined in the *Blueprint for Health Implementation Manual*.

(<http://hcr.vermont.gov/sites/hcr/files/printforhealthimplementationmanual2010-11-17.pdf>)

Endnote

For more information on the Blueprint, please see the *Vermont Blueprint for Health 2010 Annual Report to the Legislature* at the following link:

http://hcr.vermont.gov/sites/hcr/files/final_annual_report_01_26_11.pdf

For general information on Vermont's Health Care Reform efforts please see the following link: <http://hcr.vermont.gov>

Respectfully submitted,

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