



VERMONT
Blueprint for Health



Smart choices. Powerful tools.

2007 Annual Report

January 2008



Agency of Administration
109 State Street
Montpelier, VT 05609

Department of Health
108 Cherry Street
Burlington, VT 05041

January 3, 2008

In accordance with subsection 702(i) of Title 18, I am pleased to submit this 2007 Annual Report on the Blueprint for Health.

The Blueprint is a visionary program intended to guide a process of transformation for the way clinical care is delivered in Vermont communities. Ultimately, the results of this systems level change should include high quality healthcare and improved control of chronic disease, effective community based self management and prevention, optimal use of health information technology, and financial reform that sustains these processes and aligns financial incentives with healthcare goals.

This report provides a detailed look at the Blueprint healthcare and prevention model, an update on the current status of the transformation process, and a discussion of the plans for achieving the programs goals.

Please feel free to contact me for questions or clarification.

Sincerely,

Craig Jones, MD
Director, Blueprint for Health
Agency of Administration
5th Floor
109 State Street
Montpelier, VT 05609
802 828 1350
craig.jones@state.vt.us

OVERVIEW

The overall goal of the Vermont Blueprint for Health is to reduce the health and economic impact of the most common chronic conditions. The Blueprint is intended to achieve this goal by leading a transformative process that results in high quality healthcare and effective prevention statewide. In particular, the program is intended to help primary care providers operate their practices as advanced medical homes, offering patient’s well-coordinated care that is supported by local services, health information technology tools, and provider reimbursement mechanisms. The high level of care that is envisioned should incorporate strategies to enhance self management and should be closely integrated with prevention efforts. If successful, this transformation could effectively establish a functional network of independent medical homes that bring to life the principles in Wagner’s Chronic Care Model. The level of healthcare reform called for in the Blueprint requires sustainable systems level change, a complex process that is intended to be achieved through public-private partnerships.

This report will review the current status of the Blueprint in the context of stages of change. These stages reflect an evolution from routine care to highly coordinated care and prevention (Figure 1).

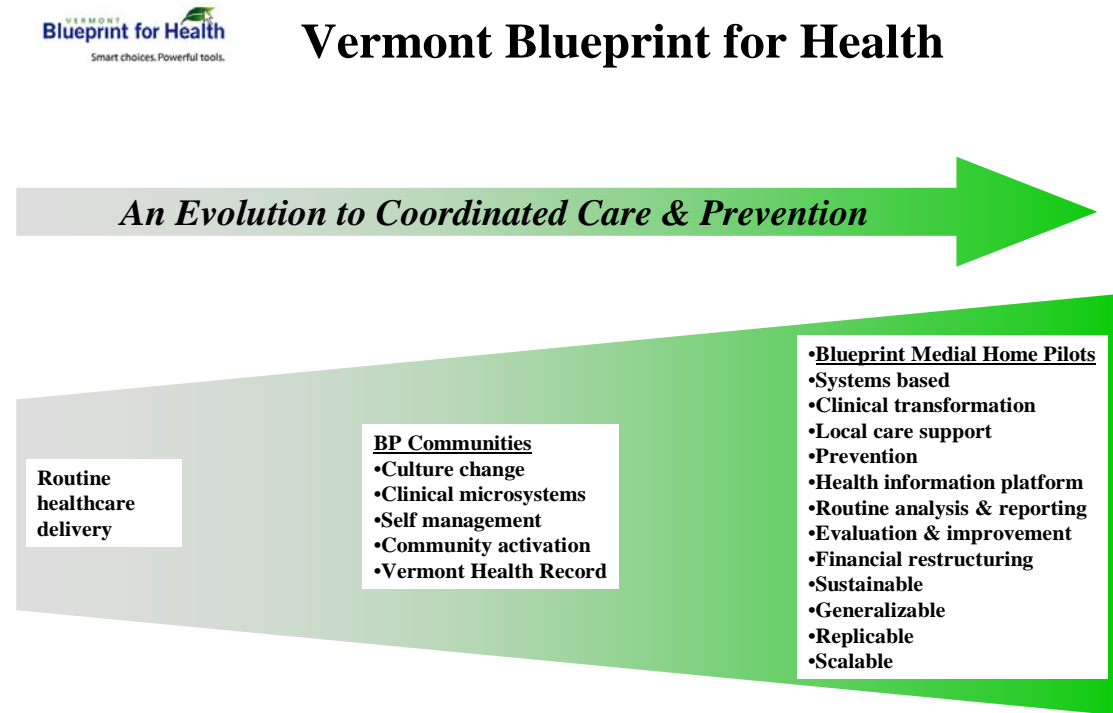
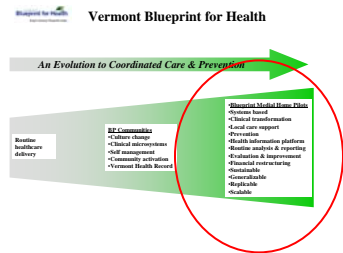


Figure 1. Blueprint programs support community transformation from routine heath care to coordinated care and prevention.

The first portion of the report will discuss the progress that has been made towards implementation of advanced medical home pilots in two communities. These pilots represent a more complete transformation process that includes; a) changing the routine flow and operations in a healthcare delivery setting, b) well coordinated care using local support services, c) reform that aligns financial incentives with the goals of healthcare excellence, d) a health information exchange platform that meets the needs of providers and patients and supports evidence based care, e) a structured approach to best practices through a routine process of evaluation and improvement, f) self management programs and techniques that lead to long term behavioral change, and, g) an infrastructure that can implement effective and sustainable prevention programs in a community.

The second portion of the report will address the transformation that has occurred in a broader context across the state. The Blueprint has initiated programs which have helped to guide the cultural and functional evolution that is necessary to support the operations of a medical home. Blueprint communities have each established a framework for change based on local needs and resources. This framework establishes a readiness to adapt the sustainable infrastructure that will be tested and refined in the medical home pilot communities.

SECTION 1: PROGRESS TOWARDS IMPLEMENTATION OF ADVANCED MEDICAL HOMES IN VERMONT



Introduction

Act 71 of the 2007 Session calls for pilot projects, designed to “demonstrate and evaluate best practices in the integration and delivery of chronic care.” The timeline for implementation includes an initial community by January 1, 2008 with implementation in at least one additional community by July 1, 2008.

The Blueprint is making steady progress toward this admirable goal guided by the vision and directives that are detailed in Act 71. Efforts are underway to implement medical home pilots in two communities based on a design with a keen focus on; a) a well integrated healthcare and prevention model that is scalable and replicable, b) sustainability achieved thru systems level change and financial reform, and, c) an infrastructure for evidence healthcare supported by information technology.

The Blueprint Team has worked with a broad set of stakeholders to design a model for implementation of the medical home pilots. The model is designed to make the

conceptual design of a medical home come alive. This includes a scalable approach to provider coordinated and local community based management of chronic conditions, close integration of healthcare delivery and prevention, a health information platform to support evidence based operations, and financial restructuring to support sustainable reform. In effect, the model provides a framework to accomplish the goals outlined in Act 71 and to establish a functional network of advanced medical homes across Vermont.

The Medical Home model in Act 71 formed the basis for an RFP sent to the six Blueprint communities on September 29, 2007, with responses due November 1, 2007. The Blueprint Executive Committee provided a forum for detailed discussion of the priorities for the pilots, which informed the following criteria used to evaluate the merits of the proposals: a) the most complete approach to an advanced medical home and achieving the goals of the model, b) a clear rationale for their proposed Community Care Teams, c) the best use of existing resources and infrastructure, d) the ability to extend services to underserved populations, e) the likelihood of expedient expansion so that a functional network of medical homes would be established within the first year, and, f) the readiness to maximize the use health information technology, participate in health information exchange, and establish an evidence based infrastructure for health and prevention.

Responses to the RFP were submitted by the Blueprint teams from United Health Alliance (Bennington), Fletcher Allen Medical Center (Burlington), and Northeast Vermont Medical Center (St. Johnsbury). The proposals from Northeast Vermont Medical Center and Fletcher Allen were determined to; a) be the most complete, b) represent the greatest opportunity to implement and integrate all key aspects of advanced medical homes, c) be the most culturally ready for implementation of advanced medical homes, d) and to the greatest degree meet the principles called for in Act 71. As such, the plan is to have the St. Johnsbury program begin implementation in January 2008, and the Fletcher Allen program begin implementation by July 2008.

Blueprint medical home model

The model used to establish the basis for the Blueprint pilots is shown in Figure 2. It is designed to provide a functional framework for a medical home built on the principles of the Chronic Care Model.

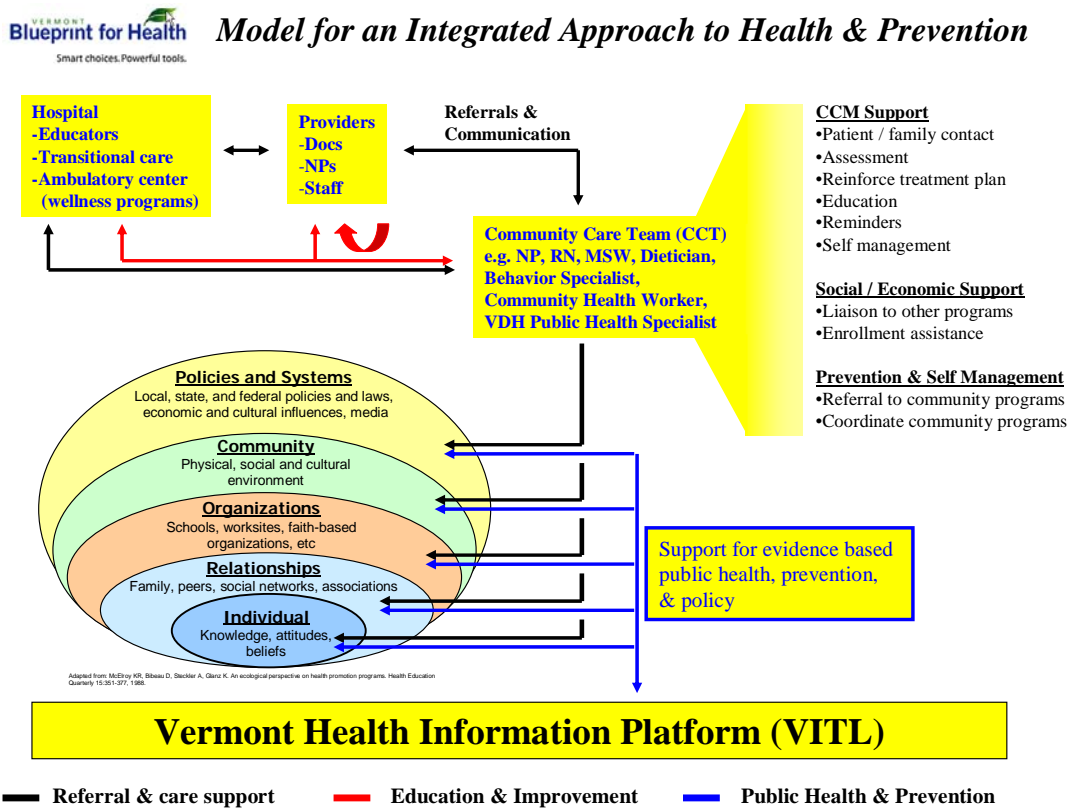


Figure 2. Model displaying the proposed organization and operations for the Blueprint medical home pilots.

The pilots will provide an opportunity to test strategies in an iterative fashion and to establish an evidence-based and sustainable infrastructure for practices that want to become health information enhanced medical homes. To accomplish this, pilot sites have agreed to the following goals and commitments:

1. The pilot will establish local disease management support services in the form of a Community Care Team (CCT). The staffing and administrative structure for CCT operations will be based on each pilot site’s proposal and, where possible, will build on existing infrastructure and reflect the needs in the community. The intent is to have a flexible locally designed approach based on the expertise of the leaders in the Blueprint communities. It is important, however, that the staffing structure for the CCT includes expertise that can support the following goals and activities.

2. The CCT will form a local infrastructure that will support **primary care provider-coordinated care** for chronic conditions in accordance with national guidelines (or locally approved guidelines that supersede national standards).
3. Primary care providers and the CCT will work together to provide outcomes-oriented care such that **the intensity of contacts, visits, and services will be guided by the principle of optimizing clinical outcomes for each patient** with a poorly controlled chronic condition(s).
4. The CCT will form a **local infrastructure to support evidence-based self management** activities for individual patients and patient groups.
5. Primary care providers and the CCT will work together to provide outcome oriented **self management support such that the intensity of contacts, visits, and services will be guided by the principle of optimizing behavior change and meeting individual goals** oriented towards disease control and prevention.
6. The CCT will include a Public Health Specialist hired by the Vermont Department of Health and based at the local District Office. **Care support personnel on the CCT and the Public Health Specialist will work closely together to identify priorities and opportunities for evidence-based prevention programs.**
7. The CCT will meet on a regular basis for **evidence-based evaluation and improvement of care support and prevention activities (CCT level process evaluation and process improvement).**
8. The CCT will work with primary care providers on a regular basis to support **evidence-based evaluation and improvement of healthcare processes (Provider Practice-CCT level process evaluation and process improvement).**
9. Primary care providers, the CCT, the local Blueprint teams, and appropriate hospital administrators and staff will work together to implement a transitional care approach for patients with chronic conditions who are hospitalized. The goal is to have a **structured approach that streamlines, simplifies, and optimizes the opportunity for hospitalized patients to transition to effective outpatient management.**
10. The local Blueprint team, including primary care providers, will work with the VDH Blueprint team, the Blueprint Director, payers, and other key stakeholders to **obtain a commitment from the payers for financial support of the CCT for a two year pilot period.** During the first year the Blueprint and each payer will provide an equal share of financial support for the costs of the CCT. The local pilot Blueprint teams, the VDH Blueprint team, the Blueprint Director, payers, and other key stakeholders will begin planning a sustainable financial support model that is evidence and experience based, and transitions financial support to

- the payers at the beginning of year 2 of operations. **The ultimate goal is to have payers transition their disease management/care support expenditures from distant to local CCT services, if this local model is deemed to be more cost and quality effective.**
11. **The local Blueprint team, including primary care providers, will work with the VDH Blueprint team, the Blueprint Director, payers, consultants, and other key stakeholders to establish a common structure of provider payment reform for the Blueprint pilots.**
 12. The local Blueprint team including primary providers will work with the VDH Blueprint team and the Blueprint Director to **determine; a) how a clinical tracking system offered by the Blueprint can be used to support care in the medical home pilots, and b) to plan that system's implementation in the pilot practices.** In addition to care support, the clinical tracking system will offer providers and the CCT the opportunity to coordinate care and conduct evidence-based population management. Ideally, the system will establish an infrastructure for health information exchange in practices that don't have an electronic medical record (EMR), and will supplement operations in practices that use EMRs.
 13. Appropriate leaders from the local Blueprint community will work with the VDH Blueprint team, the Blueprint Director, leaders from Vermont Information Technology Leaders (VITL), and other key stakeholders to **establish a Business Associate Agreement (BAA) with VITL for the purpose of Health Information Exchange.** This will optimize the usefulness of clinical tracking systems for care delivery, process evaluation and improvement, outcomes evaluation, and epidemiologic research.
 14. Appropriate leaders, faculty, and personnel from the local Blueprint community will work with the VDH Blueprint team, the Blueprint Director, and other key stakeholders to **develop an evaluation plan that will support; a) routine program evaluation and improvement, and, b) outcomes analysis including health process, health impact, and health care cost measures.**
 15. Appropriate leaders from the local Blueprint community will work with the VDH Blueprint team, the Blueprint Director, payers, and other key stakeholders to **obtain a commitment from each payer for a cohort-matched, claims-based evaluation of the impact of the program.** This evaluation should provide a collaborative opportunity to evaluate health care delivery patterns, clinical impact, and cost of care.

Each of the selected pilot communities has agreed to these commitments and goals which are necessary to establish an evidence-based and sustainable infrastructure for medical home expansion across the state.

The Blueprint Medical Home Pilots

The Blueprint Medical Home pilots will be implemented with an emphasis on meeting the needs of patients, families, and providers. At its core, the Blueprint model is designed to help primary providers optimize clinical operations and establish themselves as a familiar focal point for care coordination. However, the scope of the pilots goes well beyond. The pilots will in effect reform healthcare delivery and prevention at a systems level. Incentives are re-aligned, barriers to care are minimized, and a model is put into operation that is designed to engage communities in disease control and prevention.

The pilots will test and refine strategies in order to establish a functional infrastructure that is replicable, scalable, and financially sustainable. Specific progress and plans related to key components of the pilots are described in this section including; **a)** financial reform, **b)** an advanced clinical tracking system, **c)** routine evidence based process evaluation and improvement, **d)** local Community Care Teams that provide an infrastructure for care support, self management, and prevention, **e)** integration with broader community prevention efforts, and, **f)** a systematic approach to program evaluation including a model for statewide data management, analysis, and reporting.

a. Financial reform

The first Blueprint Medical Home pilots will focus on two major areas of financial reform; provider payment and sustainability for local community care teams. The Blueprint team is working with consultants and key stakeholders to design a provider payment structure that will support clinical transformation, care coordinated by the primary provider, incentives for high quality care, and will be common across payers. A series of meetings facilitated by consultants has been held and initial recommendations for this payment structure have been reported. These recommendations have been provided to payers, providers, and other key stakeholders for review. The recommendations have been presented for review and discussion to the Blueprint Executive Committee, and are attached as Section 3 of this report. Interested parties are currently evaluating the recommendations and preparing feedback. In January 2008, the consultants will facilitate a focused set of meetings with the payers to negotiate an acceptable approach to a common payment structure. The goal is to have a well-defined approach negotiated by February 2008, and to implement these changes as part of the first medical home pilots this winter and summer.

The Blueprint team is also working with payers to structure a plan for financial sustainability of the local Community Care Teams in the two pilot communities. The current plan is to have each payer and the Blueprint pay a portion of the costs for the first year of operations. During the first year, these same stakeholders will work together to develop an experience and evidence based financial support model. The plan is for the payers to fully support the costs for the Community Care Teams in year two of operations and beyond based on the model developed in year one. If the Community Care Team approach is determined to be effective, the ultimate goal is for payers to shift

expenditures from their current disease management services to support for local community care teams. This will represent a new cost for payers during the pilot phase with the opportunity to transition to a cost shift if the model is effective. In January 2008, the Blueprint team will work with payers and key stakeholders to plan a prospective cohort matched evaluation of the Blueprint Community Care Team model as compared to routine services currently offered by payers (see Section *e.* below).

b. Clinical Tracking System

Health information technology has the potential to enhance clinical operations and support ongoing process improvement. In order to maximize the use of health information technology, the Blueprint medical home pilots require a clinical tracking system with the functional capacity to support the clinical operations of a medical home. The system needs to be something that providers want to use and that has the capacity to: a) fit into routine clinical workflow for all patient care, b) support a planned visit, c) support guideline-based care and disease management for the most prevalent chronic conditions, d) provide an easy to use clinical note with anticipatory guidance, e) produce reports and treatment plans that guide individual patient care, population management, and help providers avoid wasted time writing or dictating, f) do electronic prescribing and print prescriptions, g) promote behavioral change with structured tracking of goals and self management activities, and, h) support interactions between primary care providers and local care support teams. Based on the original goals of the Blueprint program, the original design of the Chronic Care Information System (CCIS) was limited in scope and functionality. The call for medical home pilot programs in Act 71 established a need for an expanded scope of functionality and care support.

At the time of this report the Blueprint project team, with extensive input from a broad range of stake holders, is working on a timely solution. The goal is to have the best option available and operating as the medical home pilots are implemented and to have active health information exchange between this system and existing sources in the pilot communities (e.g. administrative, laboratory, clinical). The Blueprint team and VITL are working closely together to achieve these goals as the first pilot communities implement operations.

c. Process Evaluation and Improvement

With financial reform supporting clinical transformation, and a health information enhanced practice, providers will be able to engage in an effective approach to process evaluation and process improvement (PE / PI). Blueprint community providers have received Clinical Microsystems training. This training provides a structured methodology and is designed to support a routine and effective PE / PI cycle. The training includes using structured reports to identify areas for improvement, setting objectives, planning a strategy to meet the objectives, tracking measures that reflect the objectives, evaluating results, making modifications based on the results, and finally continuing this cycle on a regular basis. In a healthcare delivery setting this process improvement cycle is best accomplished with good tracking of key measures in a health information system, readily available reports, and structured time slots. Enhanced

provider payment is intended to support this process along with other aspects of clinical transformation. The Blueprint is spearheading the health information infrastructure, financial reform, and the training that can support evidence-based PE & PI. The medical home pilots will incorporate and refine these processes as part of routine operations. Key measures and change will be monitored using the health information system and standard reports.

d. Community Care Teams

The Blueprint medical home model is designed to help primary providers optimize clinical operations and establish themselves as the focal point for care coordination. Despite these reforms, chronic health conditions are often associated with a complex set of circumstances that will make them difficult to control or prevent. Contributors range broadly and may include co-morbid conditions, variable forms and severity of a disease (phenotypes), variability in the response to therapies, behavioral characteristics, and social as well as economic factors.

The support of a local multidisciplinary community care team (CCT) is designed to: a) account for these real and prevalent complexities, b) help primary providers coordinate the best health care possible, c) minimize barriers by providing easy access to familiar people and an array of essential services, and, d) help to engage patients and families in ongoing care, including the self management and behavioral change components that are so essential.

This approach supports the principles embedded in a medical home model and is quite different than the traditional disease management services that are currently offered by payers. Support services offered by payers are most often contracted and primarily based on stratification using claims and / or other assessment tools. Stratification triggers a range of interventions that may typically include: reminders and notifications (mail, phone), education materials, referral to targeted intervention programs, phone contact by coordinators or case managers, and in some cases personal contact by coordinators or case managers. Most often, the stratification, case identification, patient contact, and offered services exist as a separate healthcare process and are independent of the provider – patient relationship.

The use of local Community Care Teams will establish a primary provider coordinated model of care. Case identification and referral for care support services is initiated by the primary provider with the support of readily available health information, patterns of key health status measures, and an intimate understanding of the circumstances which are associated with the patient's health status. In effect, case identification, stratification, referral, and the intensity of services are driven by the judgment of a uniquely informed provider. Services are local, familiar to both the provider and patient, and come at the recommendation of a trusted provider. This approach realigns the emphasis of care coordination in a manner which minimizes the use of remote contact from sources

external to the unique patient provider relationship. Unlike, claims based identification; this approach accurately identifies people who can benefit from care support services.

The model also establishes services that are personal in nature, and are most likely to engage individuals in a change process that leads to improved disease control and prevention. Ideally, every practice setting would have one stop shopping with all of the multidisciplinary expertise necessary to provide patients and families with the best care possible. While this is economically unrealistic, the Community Care Teams represent a potentially cost effective option.

In the Blueprint Medical Home pilots, the staffing, expertise, and administrative management of the Community Care Teams will be based on the recommendations of the local Blueprint community. This flexible, non-prescriptive approach takes advantage of local expertise and existing infrastructure. Over its life span, the Blueprint initiative has coalesced local communities of expertise and consensus. These providers, administrators, patient advocates, and other key stakeholders have been asked to design a CCT that meets the needs of the community they work in. They have been asked to utilize an established administrative infrastructure to hire and manage the CCT. This approach is intended to put in place a cost effective care support service that is most likely to be utilized by providers and patients in their own communities.

Based on this approach, the Community Care Teams will reflect distinct differences in the two pilot communities, including: different population densities, different provider practice densities, geographic and demographic variability, social and economic variability, a different local healthcare infrastructure, and different local cultures. In effect, the Blueprint is building a culture and infrastructure that supports adaptation of a model to meet local needs.

The Blueprint model is designed to establish a sustainable and evidence based self management infrastructure in the pilot communities. To date, the Blueprint initiative has used the Healthier Living Workshop program to begin the process of building a self management culture across Vermont. The Community Care Teams establish a sustainable infrastructure that can build on this culture and broaden the use of strategies designed to encourage behavior change and enhance self management. Each individual encounter between a CCT member and a patient becomes an opportunity for the use of targeted self management strategies. The CCT will be an established resource to coordinate group efforts, including the Healthier Living Workshops. In effect, the CCT provides a resource so that the self management culture can evolve and be incorporated into daily practice and routine operations. The clinical tracking system supported by the Blueprint will be used by primary providers and the CCTs to track patient goals and self management activities.

e. Prevention

Prevention is an overarching goal of the Blueprint initiative and an integral component of the Medical Home pilots. The pilot model is designed to help establish a "prevention infrastructure" in local communities and to functionally integrate care delivery and public health based approaches to prevention. Each Community Care Team will include a dedicated Public Health Specialist (PHS) that works out of the local district office (taking advantage of existing infrastructure), who will also be part of new Community Prevention Teams in each of 12 regions of the State, comprised of the PHS and existing positions (VDH District Director and Substance Abuse Prevention Consultant). The Community Prevention Team, working together with community members, will:

- Assess the community's prevention needs based on epidemiological data
- Assist to identify other resources, including private funding & volunteer contributions
- Identify community readiness to address prevention needs and service gaps
- Develop a strategic prevention plan with community specific priorities
- Implement effective community prevention programs, policies and practices
- Oversee implementation of CHAMPPS (Coordinated Healthy Activity Motivation and Prevention Programs) Grants to communities for cross categorical community prevention development, to assure optimum utilization of resources directed at best and promising prevention activities,
- Evaluate the efforts for improved wellness outcomes

The PHS also will work closely with the Community Care Team members to identify key needs in the community based on CCT patient experiences, and use this information to help design evidence based approaches to prevention, and facilitate implementation of sustainable programs.

This approach to prevention provides several unique opportunities. Strategies will be formulated based on the prevention and epidemiologic expertise of public health experts, along with an understanding of individual patient needs and healthcare process that care delivery experts bring to the table. In addition, the design closely integrates the program development capacity of the Vermont Department of Health with healthcare delivery and community need. The team design also establishes an infrastructure that is uniquely designed to locally adapt and implement prevention programs. Based on local need and capacity, the PHS will work across the spectrum of the Vermont Prevention Model so that programs can address needs at appropriate levels (individual, relationships, organizations, community, and policies & systems).

f. Pilot Evaluation and a Model for Data Management, Analysis, and Reporting

In order to achieve its goals, the Blueprint program needs to establish a sustainable infrastructure that supports ongoing evaluation and research. At a program level, an iterative approach to determining best practices requires ongoing analysis and reporting.

Medical homes that deliver evidence based healthcare rely on readily available information to guide process evaluation and improvement. Implementation of evidence based prevention relies on epidemiologic research and ongoing tracking.

The Blueprint team is working with key stakeholders to design a process for data management, analysis, and reporting (Figure 3). These are essential processes in order for the VITL health information exchange platform to support the goals of the Blueprint. As VITL matures, a network is being established that will integrate administrative, demographic, clinical, and laboratory data. This health information exchange infrastructure provides an opportunity for optimal care support, evidence based improvement, and novel health outcomes and epidemiologic research. Making these opportunities a reality requires a structured and efficient process that supports appropriate data use.

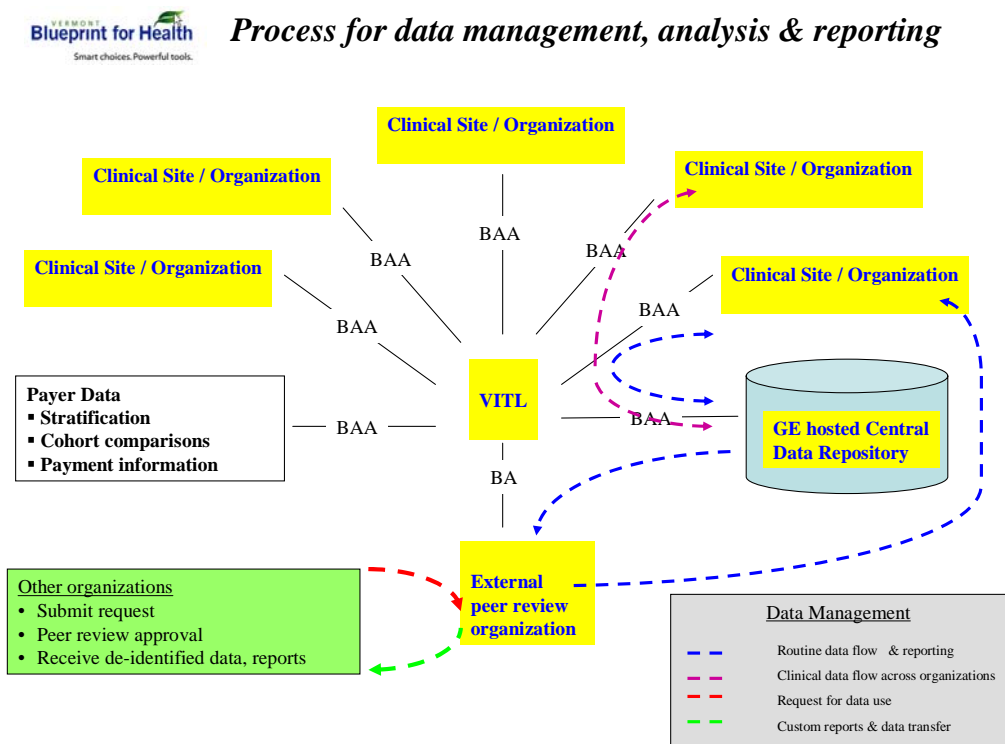


Figure 3. Proposed model for data management and analysis to support optimal patient care, evidence based improvement processes, and health outcomes as well as epidemiologic research.

In this model, each participating clinical entity / organization enters into a business associate agreement (BAA) with VITL. As part of this agreement the processes, rules, uses, and patient protections for health information exchange are defined. With patient agreement, integrated data will be available for 1) direct care delivery at the clinical site(s) where a patient normally receives care, and, 2) across clinical organizations as necessary. Appropriate audit logs and records will track the use of data for care delivery.

In addition, VITL would have a BAA with another entity that will use a peer review process to oversee the use of multi-source data for purposes other than direct healthcare delivery. Ideally, this entity will also provide essential services that are not readily available to clinicians and organizations including data management, analyses, and reporting. This approach establishes a core resource that supports optimal care delivery and evidence based improvement.

It is important to note that this model is not currently a reality. Discussions are underway with VITL and Blueprint community hospitals to develop a BAA for the health information exchange platform. In addition, discussions are underway to determine an entity that is best suited for data management, analysis and reporting and what would be required for implementation. Ideally, this or a similar sustainable infrastructure will support essential services and help to maximize the use of health information technology as called for in Act 71.

The Blueprint is working toward a multi-tiered approach to evaluation, particularly as it relates to evaluating the impact of the medical home pilot models. The pilot practices will be delivering care to a general population with insurance coverage that includes all of the payers in Vermont. This presents a novel opportunity to collaborate with payers and to conduct a population based evaluation of healthcare delivered in the medical homes as compared to routine care.

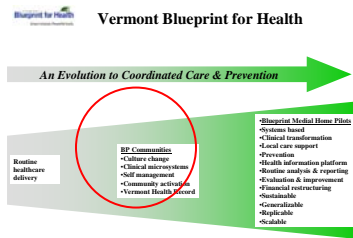
The Blueprint team has outlined a strategy for this comparison and will meet with payers in January 2008 to plan the details. The goal is to utilize claims data to evaluate outcomes for patients receiving care in pilot practices (intervention) as compared to a demographically and clinically matched cohort (routine care). The proposed design includes a case identification step so that patients who receive care in the pilot practices would not be eligible for disease management services offered by payers. This would allow a prospective evaluation to compare patterns of healthcare delivery, outcomes, and resource utilization.

Although the opportunity for a robust evaluation is real, it is important to note that the planning for this collaborative approach is in the early stages. Working with payers to plan the details, and to obtain their commitment, is underway.

Summary

The Blueprint is making substantial progress towards implementation of the medical home pilots. This complex transformation is being stimulated thru private public partnerships, is systems based, and is designed to establish a sustainable infrastructure. It is expected that the first two pilots will be operating in close alignment with the timeline called for in Act 71.

SECTION 2: A PROCESS OF TRANSFORMATION: RESULTS FROM BLUEPRINT COMMUNITIES



Introduction

Substantial transformation is required before a healthcare community can become a functional network of medical homes coordinating with a local care support and prevention team. The work flow within a clinical setting must adapt to the use of health information technology along with routine visits that are more structured, thorough, and consistent. Providers need to adapt a structured approach to evidence based healthcare as well as process evaluation and improvement. A culture oriented towards enhanced self management, goal setting, healthier living, and prevention needs to be established among patients and families, as well as among providers. The Blueprint initiative is designed to help communities through this change process with the goal of implementing systems-level transformation statewide by 2011.

This section of the report will review the progress towards transformation that Blueprint communities have demonstrated in the areas of; a) clinical transformation supported by provider training and incentives, b) guideline based diabetes care and evidence based improvement, c) enhanced self management achieved with a community based peer education program, and, d) locally designed wellness and prevention programs. This section will also discuss the progress that the Blueprint is making towards a systematic approach to evaluation, and plans for expansion in the context of a stable budget.

Clinical Transformation, Provider Training, & Practice Improvement

One of the most important processes of change occurs at the provider practice level. A clinical work flow needs to be adapted that systematically and consistently supports guideline based care as well as evidence based improvement. Ultimately this work flow should be supported by good health information technology and financial reform. The Blueprint has worked closely with the Vermont Program for Quality in Health Care, Inc.(VPQHC) to establish learning communities that assist providers with education, training, and strategies that support this change process. During the most recent reporting period, at least 59 training programs were sponsored covering essential topics including:

- Clinical Microsystems methods for improvement
- Coaching, the Chronic Care Model

- Self Management & Goal Setting
- Clinical Information Systems and Decision Support
- Increasing the Reliable Delivery of Care
- Lipid Disorder Management
- Therapeutic Approaches to Glycemic Control
- Prediabetes and Metabolic Syndrome
- Screening and Management of Diabetic Renal Disease
- Hypertension, Screening and Management of Lower Extremity Vascular Disease
- Motivational Interviewing
- Promoting Healthier Weight in Adult Primary Care (toolkit), and,
- Managing Diabetes on an Inpatient Service

These sessions have helped to establish a readiness to change and to link practice improvement with guideline based care. In 2008, providers and practices will be able to "reach the next level" with implementation of a good clinical tracking system that displays patterns of key measures, supports a planned visit, and produces reports that support population management. The combination of training and reliable health information will support daily operations that meet the Blueprint goals. At the same time, financial reform will be negotiated and tested in the medical home pilots. If effective, these resources will be ready to support more complete transformation in additional communities.

The following sections summarize provider training & practice improvement activities in each of the Blueprint communities. They are based on reports submitted from the local communities.

Central Vermont Physicians Group. Blueprint staff completed chart reviews and analysis of the data for 11 of the 12 participating practices. Nearly 900 chart audits were provided to each practitioner. Monthly evening learning sessions were offered that included the Model for Improvement, the Chronic Care Model, Clinical Microsystems and various topics of interest including treatment of hypertension, diabetes and motivational interviewing. Over 75% of the practices were present for each one of the learning sessions. A total of 9 evening meetings were held. VPQHC offered education sessions for the practices. All practices worked on either implementing or revising current flow sheets, expanding the tracking list to include items such as foot, eye exams, and microalbumin. Additionally, some practices evaluated the roles of nursing and other team members in providing chronic care management. Nursing roles changed to include follow up between visits, as well as assessing for peripheral neuropathy.

Fletcher Allen Health Care. FAHC established monthly all-practice team meetings (attended by the physician leader, site supervisor, a scheduler, and up to two other individuals from each of nine practices.) Team meetings include in-service presentations (community resources as well as support from FAHC's department of Community Health Improvement), training (motivational speaking techniques), and information on available

resources such as Healthier Living Workshops and the Vermont Regional Diabetes Center. Break-out sessions allow practice teams to share best practices and to identify problems and identify solutions. FAHC is expanding education sessions about the Blueprint for Health and the Chronic Care Model to include all staff at 9 practices (approximately 275 individuals). Provider practice teams attended Microsystems training in February 2007. Two initial focus areas were identified after this training; message handling and prescription refills. Practice teams hope to streamline and standardize these two areas. A diabetic protocol flow sheet was developed and is being incorporated in 9 practice sites. 100% of FAHC primary care providers and pertinent FAHC adult primary care staff were trained on the Vermont Diabetes Information System (VDIS)/Maple registry. 100% of diabetic patients were identified. 100% of the VDIS data base was populated with historical lab results. 100% of office staff and providers in the FAHC adult primary care practices were educated on the Blueprint for Health model, the model of Change (PDSA) and Clinical Microsystems. All 10 site supervisors and site team members attended a 4 hour-long session on CCM and Microsystems.

Mount Ascutney Hospital and Health Center. A local Blueprint implementation team has been structured which meets weekly with nursing, administration, quality improvement personnel, physician champions, and self management staff to shepherd the work of the Blueprint and to achieve program goals. The local Blueprint implementation team has worked to implement Microsystems changes and plan events that will improve systems, processes, and outcomes of care. Mt. Ascutney continues efforts to improve Microsystems within the office to support best practices in chronic care management. They are striving to improve referral system tracking and case management. 100% of the practices are enrolled in the Blueprint and are using Crystal reports. 100% of providers have been trained in Blueprint self management and community pieces. Providers are implementing the chronic care model and 100% have agreed to common measures.

Northeastern Vermont Regional Hospital. NVRH held a collaborative training in October and spent the intervening time practicing what they had learned in training. NVRH held a Chronic Care Summit which was attended by 70 people from around the state. Providers and staff attended 80% of the scheduled Blueprint education and training sessions. 85% of providers decided to enroll in Blueprint and 100% of the participants developed strategies to achieve Blueprint goals. 85% of providers have had training on the Blueprint/Chronic Care Model, model for change, clinical Microsystems, use of the Registry and information technology, self management, and community programs. 100% have developed a communication strategy regarding Blueprint implementation. 85% have had education on CCIS (or another application provided by Blueprint), and 85% of providers use the Chronic Care Model.

Springfield Hospital. Springfield holds a 3 hour collaborative session every two months, supported by VPQHC. Education on the Chronic Care Model, Clinical Microsystems, and the Model for Improvement has been completed, and new staff and clinicians are updated on this information. They participate in VPQHC statewide learning sessions and conference calls. Two teams participated in a learning session on reliability. Four teams have team meetings every two weeks. Dr. Clay has implemented the use of group visits

for diabetic patients. The group plans to meet every 3 months and have met twice at the time the local report was submitted. Chester Family Medicine was added as a Blueprint practice and is fully involved in the collaborative. 22 out of 27 practitioners are actively involved in the chronic care process. 100% of the practices are using the registry and 78% of the patients are in the registry (992 patients).

United Health Alliance. 15 of the 19 (79%) United Health Alliance providers are enrolled in the Blueprint, and 34 of the 41 (83%) primary care providers are enrolled in the Blueprint. There have been 5 learning sessions on the Review of Clinical Microsystems. Make-up sessions for new practices and staff have been held. Hypertension guidelines and treatment for Hyperlipidemia, Motivational interviewing, and Patient focused electronic medical records have been discussed. There have been 6 Collaborative sessions on Clinical Microsystems implementation facilitated by VPQHC. 12 of the 15 participating providers (80%) completed at least one Clinical Microsystems process improvement cycle. 100% of providers and staff have had education on Clinical Microsystems and tools. 100% of providers are using registry reports to support chronic care management.

Guideline Based Care and Evidence Based Improvement

To date, the provider training and practice improvement activities have been focused on diabetes. Although the measures that have been tracked are related to diabetes care and disease control, the strategies that have been implemented and the lessons learned can be generalized. The results that have been reported by Blueprint communities suggest improvement in provider practice operations and population health status measures. It is important to note that the observed benefits have occurred without health information support that fits into the daily work flow, and without true financial reform. It is also important to note that the results reflect tracking of select measures in select provider practice settings using inconsistent methods. They do not represent true population monitoring with a standard methodology, something that will become a reality this year with both a good evaluation plan and clinical tracking system in place.

The following are examples of important measures reported for 2007, as compared to national averages and Blueprint goals. These results demonstrate that overall, Blueprint communities are exceeding national averages for some very important measures. They also demonstrate variability. The reasons for the variability are not evident and may be due to a wide range of factors including differences in healthcare delivery, differences in the methods of data collection and tracking, or differences in the populations that are being served. Published data demonstrate that something as straightforward as visit interval may influence these types of results. If anything, these data demonstrate the importance of a good clinical tracking system supporting consistent methodologies across all communities. With this in place it will be possible to evaluate the factors that contribute to variability, and to use that information to guide quality improvement activities.

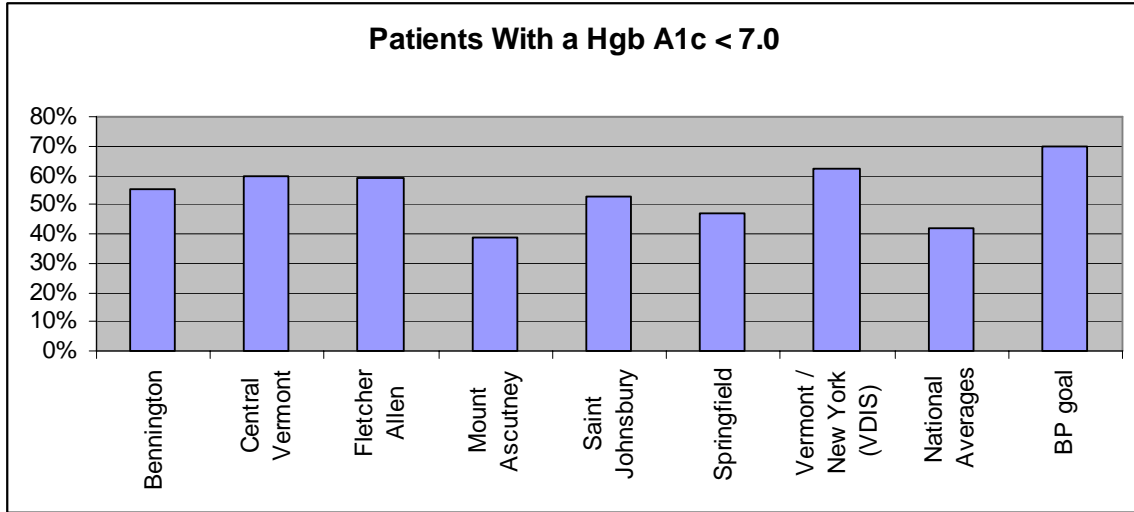


Figure 4a. Percentage of diabetic patients treated in Blueprint practices with a Hgb A1c < 7.0 (2007 data).

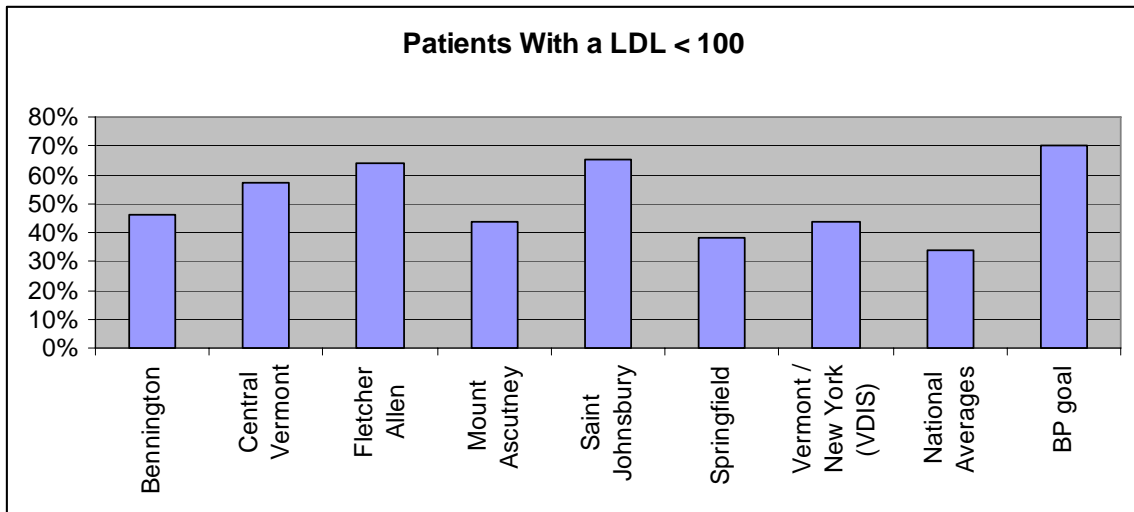


Figure 4b. Percentage of diabetic patients treated in Blueprint practices with an LDL < 100 (2007 data).

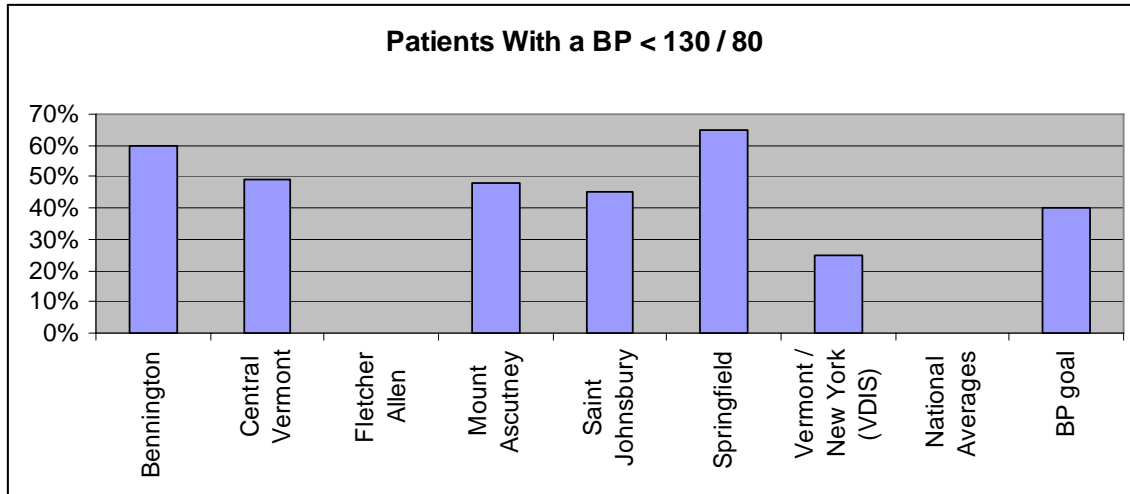


Figure 4c. Percentage of diabetic patients treated in Blueprint practices with a Blood Pressure < 130/80 (2007 data).

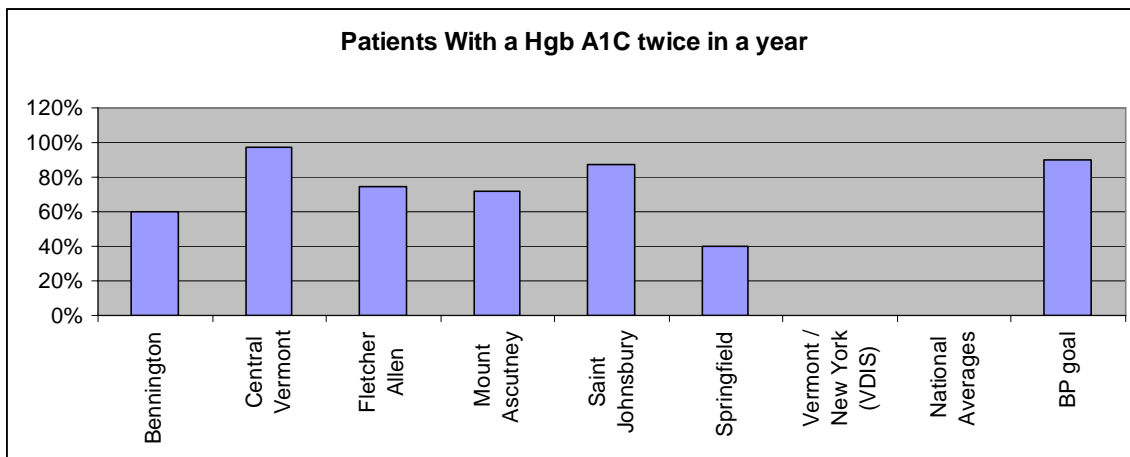


Figure 4d. Percentage of diabetic patients in Blueprint practices with their Hgb A1C checked twice in a 12 month period (2007 data).

The first three measures are associated with a patient’s level of disease control and long term risk for adverse health outcomes. The fourth measure reports a process of care that is recommend in current guidelines. Charts such as these display a snapshot and reflect both the strengths and weaknesses of current Blueprint initiatives around the state. Qualitatively, the reports submitted by Blueprint communities suggest that many practices have instituted better and more consistent approaches to diabetes care. The objective results that are submitted suggest that many patients are meeting the goals outlined in national and local guidelines. However, the ability to use data to support individual patient care, population management, and process improvement can be greatly improved. Results such as these don’t tell a complete and most useful story. They don’t reflect change over time or provide information about the impact of a particular intervention. Most importantly, the results that have been provided are tracked using

different methods and require a substantial time commitment on the part of practices that is in addition to already busy schedules.

As previously described, a clinical tracking system is needed that fits into the normal work flow and supports patient care during a routine visit. In order to fit into the routine work flow, the system needs to support care and display important information for all patients. Its use cannot be turned on and off for a particular condition or a small number of patients. The system must be able to easily produce views and documents that are useful while the patient is being seen (point of care), as well as reports that can be used to guide population management, practice evaluation, and improvement processes. If a system with these qualities is in place, meaningful measures will be collected on a more consistent basis. It will be possible to use key measures to segregate patient groups and to guide the intensity of visits and health services based on this information. It will also be possible to learn what processes are associated with better outcomes, and what variables are associated with unfavorable outcomes. In addition, it will be possible to have a meaningful understanding of the health status of populations across the state. As described in a previous section of this report, the Blueprint team and key stakeholders (e.g. VITL) are reviewing options that will make a system with these qualities available in 2008, and, for the first time, support transformation to real-time evidence based practice.

Enhanced Self Management

Enhanced self management through behavioral change is essential in order for patients to control and potentially modify the course of chronic disease. Effective chronic care management depends on providers and patients working together to bring about behavioral change. Currently, routine health care in the United States is episodic and reactive. Enhanced self management through structured and proactive processes requires substantial transformation at the level of the provider, practice, and community.

The Blueprint has initiated this transformation, and established a readiness to change across Vermont (Figure 5). A structured approach to enhanced self management has been implemented in the six Blueprint communities and in non-Blueprint communities (Brattleboro, Northeast Kingdom, Randolph, Rutland, White River Junction). Brattleboro and Rutland are in their second grant year while the Veteran's Administration Hospital in White River Junction was a new addition for FY 08. Grace Cottage Hospital is very interested in joining the Healthier Living Workshop partnership and has two new leaders that are successfully trained.

An evidence based and consistent approach to self management has been utilized across the state. The Healthier Living Workshop (HLW) program is a validated methodology based on a series of group meetings and a structured curriculum. Workshops are facilitated by trained peers who have a chronic condition themselves, have experience as a care taker for someone with a

chronic condition, or, know someone with a chronic condition. The 2 ½ hour group meetings are held weekly for a total of 6 weeks. The focus of the program is to help individuals learn a systematic and structured approach to: Problem Solving, Goal Setting, Skill building, Taking Action, and, Building a Support Network. The curriculum provides participants with important knowledge and tools including; a) the importance of physical activity and eating healthy, b) planning and managing fatigue, c) understanding medications, d) better breathing, e) working with their health care team, f) problem solving, g) pain management, h) communication, and, i) understanding emotions.

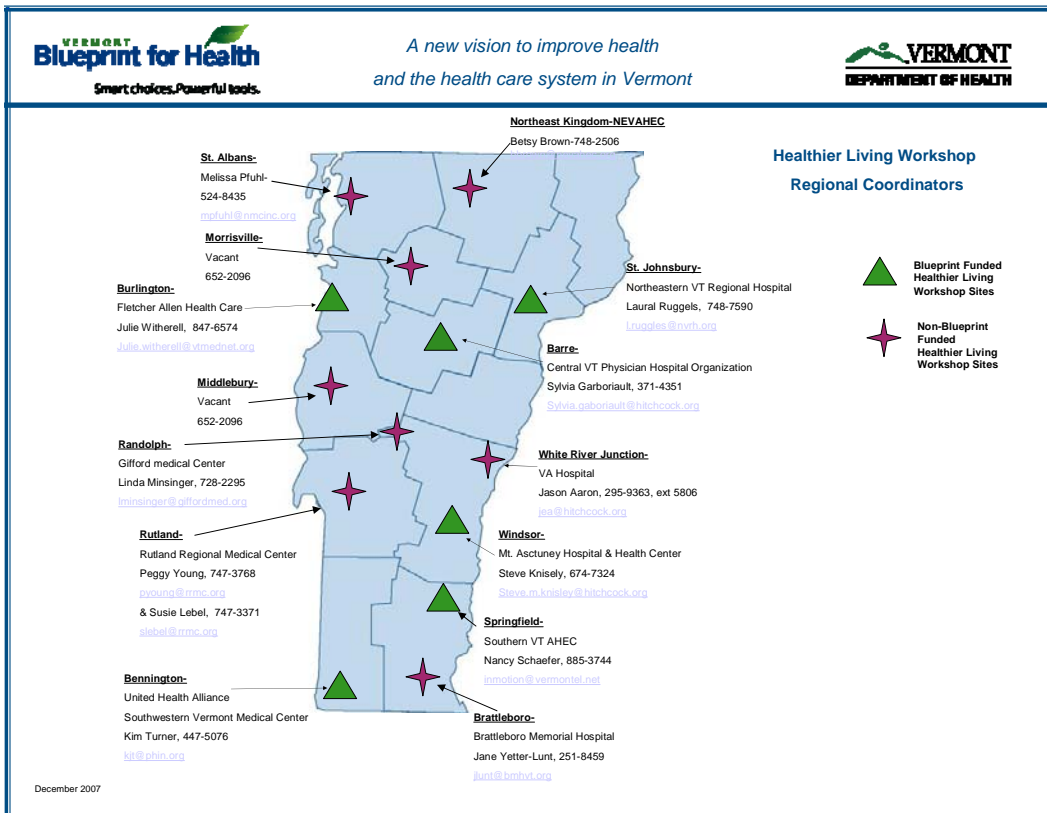


Figure 5. Location of Blueprint supported self management programs across Vermont.

This year (thru November 2007) there have been 74 workshops held with 865 participants. 581 participants have successfully completed the six-week course statewide. There are 16 workshops scheduled between January and May 2008, with more in the planning stages. The Blueprint initiative has developed a "self management network" of regional coordinators and trained leaders. There are 12 active regional coordinators in the state, with only 2 areas (Morrisville & Middlebury) that do not have a local coordinator (covered by other coordinators). In addition, there are a total of 91 trained leaders throughout the state (Table 1). Planning is underway for leader training in the

springtime of 2008 in parts of the state where there is greatest need for more leaders (northern and southern portions).

Table 1. Distribution of Trained Healthier Living Workshop Leaders across Vermont

Trained HLW Leaders in Blueprint Communities			Trained HLW Leaders in Non Blueprint Communities		
	Active Leaders	In-Active Leaders		Active Leaders	In-Active Leaders
St. Johnsbury	7	3	St. Albans	4	0
Barre	8	2	NEK	8	1
Burlington	14	3	Morrisville	0	0
Windsor	1	0	Middlebury	0	0
Springfield	9	0	Randolph	4	0
Bennington	9	1	WRJ	7	0
Total			Rutland	11	0
			Brattleboro	9	1
			Total		

The HLW program has a built in evaluation component. Participants are asked to complete a baseline evaluation. Follow-up evaluations are forwarded to each participant who completes the course at six month and twelve month follow-up intervals. The evaluation forms are returned to the state coordinator and entered into a spreadsheet for tracking purposes.

The results from these evaluations have demonstrated a sustained improvement in the participant’s capacity for self management and a reduction in resource utilization (Figure 6). Participants who complete the program report: a) a decrease in physician and emergency room visits, b) a decrease in frustration, fatigue, fear, and the effects of pain, c) improved confidence about doing things without interference from their chronic condition, d) an increase in physical activity and activities of daily living, e) an improved understanding of their health condition and medications, and, f) an improved capacity for figuring out solutions to problems. Although subjective, the provider and participant testimonials have been impressive and reinforce the potential for a structured approach to enhanced self management. These results are encouraging and highlight the importance of improved self management as part of the overall transformation.

Healthier Living Workshops *Impact on resource utilization*

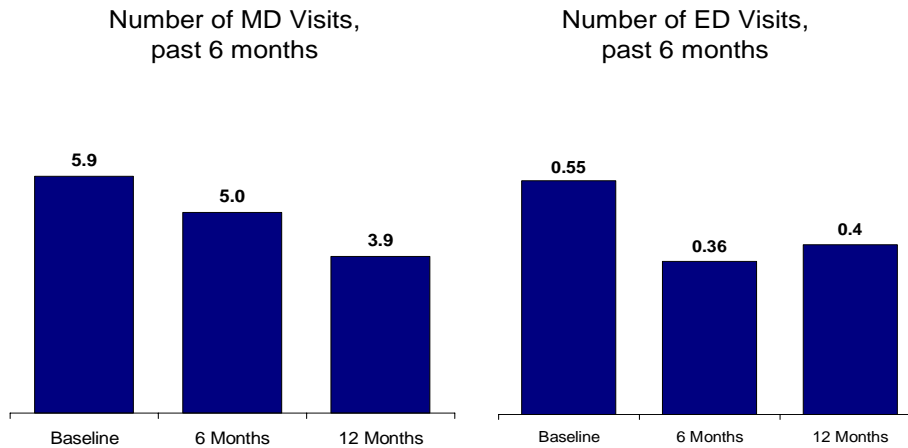


Figure 6a. Visits to a doctor’s office and to the emergency room decreased significantly when comparing the 12 month post-workshop surveys to the baseline interviews.

Healthier Living Workshops *Impact on Confidence about doing things*

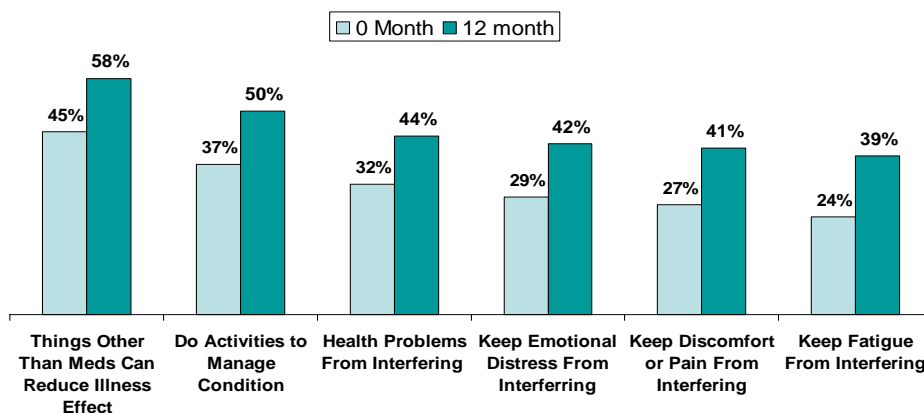


Figure 6b. Participants are more confident that fatigue, discomfort, pain and emotional distress from their condition will not interfere with things they want to do. Many also feel that they can do more than just take medications to reduce illness effects in everyday life.

The results from the Healthier Living Workshop are encouraging and they highlight the opportunity for a broader impact. To date, Blueprint efforts have been focused around a peer educator group approach (HLW). These programs have been coordinated by dedicated individuals on an almost voluntary basis. Scheduling, coordinating, and maintaining participation have been consistent obstacles. Furthermore, group efforts represent only one approach to self management.

The Blueprint Team is working to make enhanced self management a routine part of every healthcare encounter, and to build a systematic approach so that Healthier Living Workshops become a routine operation in communities. First, the clinical tracking system that is put in place should offer providers and patients an easy way to track self management goals and activities, and to see trends over time. These elements should be an important part of *every* routine visit and *every* encounter with care support personnel (e.g. Community Care Team). Second, the Community Care Teams that are part of the medical home pilots will establish a sustainable infrastructure that can be responsible for scheduling and coordinating workshops. They can also be a consistent source of patient referral and reminder phone calls. These changes represent a broader systems level approach to enhanced self management that will further the excellent transformation process that has already occurred.

Wellness and Prevention Programs thru Community Activation

Ultimately, the best "management" for chronic disease comes through prevention. Blueprint initiatives have stimulated a culture of prevention, or "Community Activation", across Vermont. The cultural transformation and readiness that has been established will be the foundation on which to build a sustainable prevention infrastructure in FY 08. The Community Care Teams in the medical home pilots will include a Public Health Specialist. This will establish an infrastructure which uniquely integrates healthcare delivery and prevention. In other communities, Public Health Specialists will be dedicated to developing evidence based programs as the community evolves towards the integrated model offered by the medical home pilot. The goal is to implement sustainable and effective prevention programs that address core public health needs such as obesity.

As part of this transformation, Blueprint initiatives have supported the development of community prevention programs in Blueprint and Non-Blueprint communities. The community programs are highly variable in nature and reflect local resources, needs, and conditions. The following sections summarize activation activities and are based on reports submitted from the local communities.

Community Activation in Blueprint Communities

Mt. Ascutney: A) Lists of resources for physical activity, exercise, nutrition and weight control were identified and submitted to Vermont 211. B) Implemented procedure that BMI is recorded for all patients. C) Collaboration with Diabetes program – engaged Certified Diabetes Educators on blueprint team. D) Identified gaps in community services with persons with diabetes. E) Developed and implemented tool for communication and feedback between programs and providers. F) Developed and implemented a plan for marketing programs to providers. These accomplishments occurred despite the fact that during FY 07 the community activation and self management coordinator at Mt. Ascutney went out on maternity leave and did not return. It took a while for Mt. Ascutney to replace her.

Central Vermont Medical Center: A) Quarterly *Healthy Community* flyer distributed to every household in Washington County. This flyer lists free and reduced cost programs as well as support groups and risk factor education programs. B) “Get Moving Central Vermont” 8 week physical activity program offered year round. Program encourages 30 minutes of physical activity most days of the week and participants track their activity and submit logs. Enrollment in this program has been very low – there seems to be reluctance to “sign up” for programs. C) Community activities – moonlight treks, llama walks, square dancing. D) Development of broad countywide coalition – Central Vermont Coalition for Health. Based on community assessment, the coalition was formed to address chronic illness, mental health, substance abuse, dental health. The District Office and Central Vermont Medical Center are active participants/leaders in this coalition.

Central Vermont Medical Center has opted out of community activation component for FY08, with this work transitioning to the District Office. This choice reflects the difficulty that a care delivery organization can have trying to implement community based prevention programs, and, supports the rationale for an infrastructure that can closely integrate care delivery with prevention such as the Community Care Teams proposed in the Blueprint medical home pilots and the new Community Prevention Teams described previously.

Fletcher Allen: A) Developed *Fast FAX* referral form to better link providers with community resources and programs. At office visits, patients are provided with this form containing a comprehensive list of available programs that they can discuss with their provider. The form is faxed to the Community Health Improvement office upon which the patient receives a follow-up phone call within three days. Received 25 referrals through this process as of August 2007. The *Fast Fax* form will be embedded into the registration process for all 9 practice sites and the Community Health Center of Burlington during the current grant year. B) Identified nine new sites for Strong Living classes throughout hospital service area. Eight classes planned for fall 2007. C) Hired a nurse to administer inpatient tobacco cessation counseling. Through 9/30/07, there were 811 inpatient contacts and 414 inpatient referrals. Training provided to 80 R.N.s on inpatient tobacco cessation. D) Forty-five “Take the Stairs” signs were installed at

FAHC UHC and East Pavilion sites. E) Information provided to VSAC, a large local employer on creating a walking campaign at the workplace. F) Diabetes Fitness Program has seen a 150% increase in participation since 2006. Ten referrals were received via *Fast Fax*, resulting in 6 new participants. FAHC began offering transportation to the program for residents of Milton.

Bennington: A) Developed a walking map of the Manchester, VT area, which includes 10 walking routes. Promotion of the maps occurred through the community walking program and an additional 600 were distributed to physician offices, businesses, libraries, parks and recreation departments, self-management workshops and through large community events. Ongoing map promotion is through BCBS and SVHC websites, the Bennington Chamber of Commerce and the Manchester Parks and Recreation Department. B) 2000 Bennington maps (previously developed) were distributed through the walking program and directly to physician offices. C) 31% of community wide walking program participants reported using the walking map, which was a 26% increase over the previous year. D) Director of Community Health and Wellness has become a part of two planning groups working on the development of two walking paths in the Bennington area (Paran Pathway and the SVHC Walking Pathway). E) Trek for Health six week community walking program had 2,023 participants from 35 towns in the hospital's service area.

St. Johnsbury: A) Chronic Care Summit held on September 20 at NVRH. Seventy people from around the state attended the workshop. Speakers included Mary Woodruff – Evidenced-Based Community Programs, a panel of complementary providers talking about pain management, and Dr. Barbara Frankowski and Sheri Lynn on Asthma in Vermont. B) Participation in the “You Can!” walking and nutrition program is “down significantly” – no numbers reported. C) Smart Growth Summit conducted on March 30, 2007 with 70 people attending. Second annual to be held April 4, 2008 and will include a key note speaker on walkable communities. D) Fit and Healthy Coalition is active and continues to be the driving force behind St. J's community activities, priorities and strategies.

Community Activation in Non-Blueprint Communities

During FY07 mini grants of \$10,00 were offered to those Department of Health District Offices without a Blueprint funded Hospital Service Area (HSA) in their district.

Brattleboro: A) Walking program was designed to offer regular planned walks to the community, focusing on adults 55 years of age and older. Fifteen volunteers were trained to lead community walks. Nine walks were scheduled covering each weekday at different times of day. The average number of walkers each week was 14, with most individual walks having only one or two participants. After the kick off walk with 8 participants, 5 walkers was the highest number achieved for any subsequent walk. B) One-on-one walking companions were also offered but only two requests were received.

Middlebury: A) “Get Moving Vergennes” and “Get Moving Ferrisburgh” had approximately 75 adults and 125 children participating. Participants tracked their activity using logs and pedometers. The program also incorporated the physical reconstruction of a walking path in Vergennes and marketing the path to the community. B) “Woman’s Boot Camp” 8 week 45 minute free workout sessions involving a combination of cardio, strength, agility and stretching for all fitness levels. The sessions were held at Middlebury Fitness. Program incorporates a buddy system for social support. Two 8 week sessions were conducted. Between 25 and 50 registered, with less than 25 completing. C) “Walk the Halls” at Mt. Abe High School allows members of the community to use the school between the hours of 5:30-8:00 a.m. Monday through Friday to walk/run in the hallways. There was no formal registration process. D) Bristol Boot Camp at Bristol Fitness was a 6 week, twice per week workout session. Participants were given a free gym membership. Three 6 week sessions were conducted. 23 participants completed. E) Women’s Open Basketball in Bristol was held every Wednesday from 7-9 p.m. and open to all women in the community of all fitness/experience levels. There were eight participants.

Morrisville: A) “Climb Mount Everest” ten week walking program in Johnson allowed participants to make virtual climbs up mountains such as Ranier, McKinley and Everest with every step they took. The program incorporated activity tracking and peer support through trained peer leaders and workshops on healthy living topics. Walking program had 101-150 registered with 25-50 completing. Workshop attendance was at <25.

Newport: A) “Walktober” walking program with about 25 participants. B) Snowshoeing events with about 25 participants.

Rutland: A) The Rutland District Office subcontracted this grant to the Rutland Area Physical Activity Coalition, which conducted its Walk Rutland program, which tracked the progress of over 40 participants. B) A significant part of RAPACs work is also advocacy for bike and pedestrian infrastructure in state road projects. The (now former) Executive Director used an ongoing Rutland Herald column to advocate for strong state policy on bike/ped components in transportation projects. C) RAPAC assisted in the planning and community marketing of a multi-use trail concept for Rutland City. The project will connect Pine Hill Park with the College of St. Joseph’s (approximately 2 miles). D) RAPAC assisted in the planning, coordinating and construction of a pedestrian walking area, complete with 150 feet of boardwalk in Rutland City. E) RAPAC worked with a local land owner, to add the Patch Pond Trail (approximately 1 mile) to the growing Rutland trail system. F) RAPAC organized bike safety fairs in Poultney, Fair Haven and Rutland City reaching 450 children and their families. RAPAC also ran a bike safety fair in cooperation with the Rutland Kiwanis, Killington/Pico Cycling Club and the Rutland Recreation Department serving 50 cyclists and included the distribution of 500 bike helmets. G) RAPAC was awarded a CHAMPPS implementation grant for FY 08 in the amount of \$112,000.

St. Albans: A) Franklin Grand Isle Move More program, run by Northwest Medical Center, was a 12 week free physical activity program which encourages tracking of

activity and the opportunity to win prizes. Volunteer led weekly walks and activities were incorporated into the program. B) “Winter Move More” focused on promoting indoor physical activity. Several exercise DVDs were purchased and donated to two libraries in the HSA. The St. Albans Free Library offered weekly group exercise DVD sessions in their conference room and offered healthy seminars (yoga, healthy eating, Tai Chi, ScoreHealth) to the community at large. In addition, indoor locations for physical activity were made available and marketed to the community (schools, St. Albans City Hall gym). Between 75 and 150 people registered for the Winter Move More program, with approximately 50 completing. C) “Golden Shoe Move More” incorporated the opportunity to win sneakers donated by a local retailer into its regular physical activity tracking program. In addition, there were 7 different volunteer led weekly walks and one bike ride in three communities (Enosburg, Isle La Motte and St. Albans). Between 75 and 100 people registered with Between 25 and 50 completing.

White River Junction: A) The White River Junction District Office focused its efforts on assessing existing physical activity opportunities in towns with >2000. They also promoted evidence based interventions including walking and strengthening programs for seniors. B) Four area specific physical activity guides were developed to be distributed at WIC clinics, senior centers and recreation centers, other community partners and via Vermont 211. The guides identify local parks and recreation departments, private clubs, walking paths and senior fitness activities. C) Walking maps for 4 of the 9 towns in the district with >2000 population. D) Valley Quest Walking Programs in two towns. Both with <25 participation. E) Senior strengthening program with <25 participation. F) Senior walking programs in two senior centers with <25 participation. G) Establishment of the Bradford Health Coalition in Bradford.

Sustainable Community Activation & Prevention

The Blueprint initiatives have helped to clarify a very meaningful message. The most significant barrier to effective primary prevention and community activation is the lack of a sustainable local infrastructure that is dedicated to these efforts. Dedicated time, technical assistance, and resources are needed to sufficiently engage the broad base of stakeholders necessary to build successful community strategies. The success realized through the New Directions substance abuse prevention initiative in Vermont has been possible only due to a sustained financial investment in prevention infrastructure. Ten Substance Abuse Prevention Consultants operate locally throughout the state to develop coalitions and provide technical support in assessment, planning, implementation and evaluation of substance abuse prevention activities. Likewise, tobacco prevention efforts benefited greatly from the influx of financial support from tobacco industry settlement dollars, which in turn developed a network of tobacco coalitions statewide. We should expect that a similar approach will be necessary for prevention efforts aimed at other risk factors for chronic disease.

In 2008 the Blueprint will begin to develop a community based infrastructure to support evidence based prevention programs. Public Health Specialist positions in the local District Offices will be dedicated to supporting community assessment, community

prevention programs, and, environmental as well as policy change, as part of broader Community Prevention Teams comprised of the PHS and existing positions (VDH District Director and Substance Abuse Prevention Consultant). In the Blueprint medical home pilot communities, the Public Health Specialists will be part of the Community Care Team. This will provide the opportunity to develop evidence based programs formulated in the context of broad based local expertise. The funding previously directed toward community activation mini-grants will be redirected to be coordinated by this community activation and prevention infrastructure.

A Systematic Approach to Evaluation

Achieving a systematic approach to evaluation is part of the transformation that is occurring in Blueprint communities, and a critical goal of the program overall. To date, evaluation has relied on several approaches including local collection of clinical data, a contracted independent evaluation, and, the self reported evaluation component included in the Healthier Living Workshop program.

Local Blueprint communities have relied on an array of methods to collect clinical data and generate reports including the use of registries (Vermont Health Record, VDIS/Maple) and chart review. The methods used reflect what can be accomplished in the context of existing infrastructure, current clinical workflow, provider commitment, and readiness to change. Most often, these methods also represent redundant tracking, additional effort that is added on to the practice workload, and a process that doesn't support the normal clinical workflow or patient encounter.

In addition, the Vermont Child Health Improvement Program (VCHIP) has been contracted to conduct an independent evaluation of the impact of the Blueprint at the provider practice level. This annual evaluation is multidimensional and includes: a) a survey based evaluation of primary care practices that ascertains their perceptions of their ability to provide chronic illness care using a validated tool (Assessment of Chronic Illness Care, ACIC), and, b) a chart review to characterize key aspects of diabetes care at all Blueprint provider practices and by all participating primary providers in the six Blueprint communities. The VCHIP report is attached for review (Section 4).

Lastly, the evaluation that is included as part of the Healthier Living Workshop program has been discussed in a previous section of this report. This evaluation is based on self report at baseline, and at 6 and 12 month follow periods for participants who complete the program.

These 'wrap around' approaches to evaluation are necessary until the infrastructure is in place to support a systematic process. In 2008 this infrastructure should become a reality as a functional health information exchange platform is established (VITL), a good clinical tracking system becomes available, and a model for shared data management and analyses is implemented. The progress towards achieving these goals has been discussed in previous sections of this report.

In 2008, defined measures will be implemented for all Blueprint communities in conjunction with the roll out of the Blueprint supported clinical tracking system and VITL supported data integration and health information exchange. The measures selected will be: a) clinically meaningful, b) inclusive of the major chronic conditions, c) able to evaluate adherence with guideline based care delivery, d) valuable for routine process improvement, and, e) able to be collected as part of routine daily processes. Thus, measure selection depends on the functionality of the tracking system and the availability of data from other sources (e.g. integration with lab results). In order to assure consistency, and avoid the need for ‘wrap around’ evaluation methods, it is most practical to define a set of key measures following confirmation of data elements that are available in the clinical tracking system, and data sources that are available through health information exchange (e.g., VITL).

Program Administration Staffing

Prior to August, 2007, the Blueprint was staffed with a project manager and lead people assigned to each of the 5 focus areas: Provider practice, health systems change, self management, and community activation / prevention. Ultimate responsibility lay with the Commissioner of Health, who is responsible for all public health related activities in the state. Recognizing the importance of the success of the Blueprint and the need for a full-time strong leader to oversee the implementation and integration of all aspects of the project, during the 2007 legislative session the Governor and the legislature approved a new Blueprint Executive Director exempt position in the Secretary of Administration's Office. Reporting to the Director of Health Care Reform, this reporting relationship allows full integration with the other aspects of health care reform and authority to act across state government. There also was agreement that the Director would have a direct “dotted line” relationship with the Health Commissioner, and share responsibility for the Blueprint resources (staff and budget) within the Department of Health. The new Director started in August, 2007.

Prior to the new Director's arrival, several Blueprint staff had decided to look for other opportunities which came to fruition in late summer and fall. As such, this provided an opportunity for the Director to re-align staff and resources to better achieve the new goals of the Blueprint as laid out in Act 71 of the 2007 Session. A major change was to name a new Assistant Blueprint Director in the Department of Health who has a clinical and public health background along with the leadership qualities that are required for a project such as this. In coordination with the Blueprint Director, the Assistant Director will supervise a team of staff within the Department that includes the skills and expertise required for such a visionary project, and that is better aligned to achieve the revised Blueprint goals of Act 71 of the 2007 session.

The role for the Blueprint Executive Committee and the working groups has also evolved. As the program works to implement systems level change the Executive Committee has taken on a critical advisory role. Instead of high level conceptual discussion, Committee meetings have become a forum for key stakeholders to deliberate

strategies, priorities, and details that are part of the transformation process. The working groups are evolving into similar roles. The provider practice, health systems, self management, and community activation groups each provide a focused expertise to test and refine strategic plans.

These changes have established an energetic and informed transformation environment. Momentum toward systems level change is steadily building and key stakeholders are an essential part of the process. This approach helps to assure that financial incentives will be realigned with healthcare goals and that a sustainable infrastructure is developed for effective healthcare and prevention.

Blueprint recognition

The Blueprint continues to receive recognition at a regional and national level. The goals outlined for the program, particularly in Act 71 of the 2007 Legislative Session, establish a well conceived agenda to address many of the most complex issues that affect healthcare. The Blueprint is action, at a State level, and this is drawing attention.

The Institute for Healthcare Improvement (IHI) is a not for profit organization dedicated to improving healthcare throughout the world. The Institute has established an academic forum and a dynamic learning environment that is intended to accelerate change in healthcare by cultivating promising concepts and turning those ideas into action. In 2007, the Blueprint was selected to participate as an IHI demonstration program. This group includes 13 participant programs from around the world that interact regularly to discuss core issues, to review progress towards achieving program specific goals and objectives, and to assist with strategic planning in a constant process of program improvement.

Due to increasing recognition of its significance in comprehensive health care reform, Blueprint leadership also has made invited presentations at national and regional forums:

- The Vermont Blueprint for Health. Meeting of the Council of State Governors – Sept 2006, Phoenix, AZ
- The Vermont Blueprint for Health. State Approaches to Improving Healthcare Access Policy Seminar. Center for Health Policy, Planning and Research – December 2006, Portland, ME
- Vermont's Blueprint for Health. National Governor's Association meeting on . Leading the Way: Elements of State Health Reform - July, 2007, Los Angeles, CA.
- Cost Containment Strategies within States' Health Care Reforms. Robert Wood Johnson Foundation State Innovations in Health Coverage National Meeting – August, 2007, Denver, CO.
- You Get What You Pay For: Structuring Payment to Improve Care. National Academy for State Health Policy's Mile High Expectations Seminar – October 2007, Denver, CO

- The Vermont Blueprint for Health: A Statewide Approach to the Management of Chronic Disease. Global Perspectives on Chronic Disease – October 2007, Calgary, AB, Canada
- State Initiatives on Service Redesign - Focus on Vermont's Blueprint for Health. United Hospital Fund Conference - December 2007, New York, NY
- The Vermont Blueprint for Health. Policy Seminar: State Approaches to Improving Healthcare Access – One Year Later. Center for Health Policy, Planning and Research - December 2007, Portland, ME
- The Vermont Blueprint for Health. Institute for Healthcare Improvement annual meeting - December 2007, Orlando, FL

In addition, the Blueprint held or participated in several forums within Vermont during 2007:

- Pay for Performance statewide meeting (In collaboration with the Agency for Healthcare Research and Quality) – Sept 2006, Colchester, VT
- Blueprint Annual Meeting with community activation focus with nationally renowned speakers Elliot Fisher and Larry Cohen – March 2007, South Burlington, VT
- The Vermont Blueprint for Health and Self Management. Grand Rounds, Rutland Regional Medical Center - November 2007, Rutland, VT
- An Update on the Vermont Blueprint for Health & Chronic Disease Management. Vermont Medical Society Annual Meeting – October 2007, Burlington, VT

Program expansion and a stable budget

The Blueprint has demonstrated the ability to stimulate substantial transformation in six healthcare communities across Vermont. Even though the pace of change is variable, each of these communities is evolving and developing the framework to adapt the medical home model. This year, two of the six will pilot the Blueprint medical home model and contribute towards refining a sustainable model. As this occurs, the other four Blueprint communities will be able to continue their transition and compete to be the next communities to adapt the Medical Home model. We will continue to strengthen the resources available to non-Blueprint pilot communities to prepare them for the program as it evolves.

The design of the medical home pilots, and the financial strategies that are being employed, establish a fiscally sound and responsible process for statewide expansion. The plan for the pilots includes a shared cost structure for year one of operations (Blueprint + payers), with transition to full payer support for most costs in year two. If successful, then a year of operations in each pilot community will lead to an infrastructure that is largely sustainable based on financial reform. This provides the opportunity for Blueprint funding to shift to new communities and a clear pathway for expansion. This approach also assures that operations will be continuously tested and refined, leading to a more adaptable model.

It is important to note that the Blueprint plans to bring about this transformation without a budget increase for FY09 by taking advantage of staff and program re-alignments in current and previous years. A budget summary for FY08 and FY09 is included in section 2 of this report.

Summary

The Blueprint is an ambitious and visionary program designed to lead a transformation so that high quality healthcare and prevention is available throughout the State of Vermont. The program is making steady progress towards meeting these goals and, in the process, taking on some of the challenges that influence healthcare nationally. In the near term, the program will implement comprehensive medical home pilot programs in two communities while assisting other communities as they build their infrastructure and readiness. Within a two year period it is likely that stakeholders across the state will be able to plan an evidence based approach to transformation of the clinical care systems in their communities.

BLUEPRINT FOR HEALTH

Budget for FY2008 and FY2009

	FY 2008	FY2009
<u>Personnel (includes benefits)</u>		
Assistant Director (vacant for 6 months in FY08)	\$ 93,631	\$ 132,480
Public Health Physician -Physician Practice (combined with Asst Director 1/01/08)	\$ 63,718	\$ -
Public Health Administrator - Self Management	\$ 57,726	\$ -
Public Health Administrator - Community	\$ 58,980	\$ -
Public Health Administrator - Prevention, Community, Patient Education	\$ -	\$ 60,454
Public Health Administrator - Community Project / Grants Manager	\$ -	\$ 65,757
Information System Project Manager	\$ 96,879	\$ 99,301
Information System Developer II (2 positions)	\$ 125,373	\$ 128,508
Public Health Informatics Physician	\$ 31,084	\$ -
Communication Specialists	\$ 50,735	\$ 52,003
Statistician/Analyst	\$ -	\$ 29,600
Business Manager A	\$ -	\$ 66,891
Administrative Support (reduced support by 25% for FY09)	\$ 66,286	\$ 52,571
District Office Personnel	\$ 209,112	\$ -
Public Health Specialists for Integrated Projects Community Care Teams (4 FTEs)	\$ 49,303	\$ 242,570
Public Health Specialists for non-Pilot district offices (.5 FTE @ 8 district offices)	\$ -	\$ 242,570
TOTAL	\$ 902,828	\$ 1,172,706
<u>Community Grants and Support</u>		
Project Management	\$ 216,300	\$ 216,300
Self-Management Coordination	\$ 60,000	\$ 60,000
Self Management - Education & Outreach & Blog	\$ 100,000	\$ 100,000
Community Activation	\$ 180,000	\$ 180,000
Community Care Teams (BP 20% share for 2 teams - Feb - June, 2008; July - Dec, 2009)	\$ 74,167	\$ 89,000
Community Care Teams (BP 20% share for 2 new teams - Jan - June, 2009)	\$ -	\$ 89,000
Rural Health Alliance matching funds (50% FY08; 100% FY09)	\$ 30,833	\$ 185,000
Practice Stipends / Provider Incentives	\$ 700,000	\$ 700,000
Self management class purchases	\$ 94,765	\$ 94,765
On-line self management program	\$ 9,437	\$ 9,437
TOTAL	\$ 1,465,502	\$ 1,723,502
<u>Contracts for Other Services</u>		
Provider Training	\$ 230,000	\$ 230,000
Evaluation, Data Analysis and Reporting	\$ 150,000	\$ 250,000
Communications Consultation	\$ 60,000	\$ 15,000
Health Systems Payment Reform Consultation	\$ 60,000	\$ 60,000
Clinical Tracking System and Health Information Exchange	\$ 1,241,500	\$ 1,340,000
TOTAL	\$ 1,741,500	\$ 1,895,000
<u>Administrative Costs</u>		
Printing, publications	\$ 40,000	\$ 40,000
Training - Staff & Contractors	\$ 21,273	\$ 38,974
State Work Group Expenses	\$ 2,000	\$ 2,000
Allocated Costs (% of Personnel costs)	\$ 302,832	\$ 367,995
TOTAL	\$ 366,105	\$ 448,969
TOTAL EXPENSES	\$ 4,475,935	\$ 5,240,177
<u>Revenues</u>		
Global Commitment	\$ 2,933,398	\$ 2,933,398
Catamount Fund	\$ 1,846,713	\$ 1,846,713
Federal Funds	\$ 27,597	\$ 27,597
TOTAL REVENUES	\$ 4,807,708	\$ 4,807,708
<u>Balance</u>		
07/08 Carry-forward	\$ 331,773	\$ (432,469)
06/07 Carry-forward		\$ 331,773
NET BALANCE		\$ 0