Vermont Blueprint for Health

Background:

The Vermont Blueprint for Health is a vision, plan, and multi-pronged approach to improving health and health care delivery for Vermonters. This framework provides the information, tools, and support required for Vermonters to effectively manage their health and well-being, as well as assist primary care clinicians with providing comprehensive, coordinated, and patient-centered care. Vermont's Blueprint facilitates a re-structuring of the state's health care system to better focus on preventing illness and complications, rather than simply reacting to acute health emergencies. This plan will help Vermonters to stay as healthy as possible, improving their quality of life, and minimizing the onset of preventable disease.

The Blueprint Integrated Pilot Program (BPIPP) realizes the Blueprint's proposed reform within several communities in Vermont, and entails broad transformation of health care financing, clinical operations, public health prevention, and development of a supportive health environment. Health care financing is transformed through the following:

- Enhanced provider payment, which is standardized across payors and based on how a practice scores against the National Committee on Quality Assurance – Patient Centered Medical Home (NCQA-PCMH) Standards
- Local multidisciplinary care support teams (Community Care Teams) funded by all payors (except Medicare) and designed to bolster patient-centered medical homes' capability to optimize patient care
- Implementing a systematic approach to community prevention that closely integrates public health and health care delivery
- Implementing a health information environment designed to improve quality and accommodate diverse practice needs.

Problem Encountered:

Although Vermont ranks highly for access to services, percentage of insured children, and overall population health, and also contains one of the healthiest cities in the nation, approximately 50% of their population is overweight (BMI > 25), and roughly 20% of this group is obese (BMI 30+). Obesity increases the likelihood of developing chronic disease, and obese individuals are almost twice as likely as non-obese persons to have high cholesterol, high blood pressure, and develop cardiovascular disease, and are seven times as likely to develop Type 2 diabetes. Vermont's health care costs were increasing, such that Medicaid expenditures increased 13.4% from 1997 and those of all insurers' increased by 9.2%. Additionally, Vermont's health care costs increased by 11.5% from 2001. Chronic care now accounts for 83% of all health care spending, 81% of hospital admissions, 76% of physician visits, and 91% of all prescriptions filled.

Solution Developed:

The major components of the Blueprint Integrated Pilot Model for sustainable and well-integrated care delivery and prevention are summarized below.

1. Financial Reform
    a. Payment to practices passed on NCQA-PCMH Standards (in addition to current payment)
    b. Shared costs for Community Care Teams
    c. Includes Medicaid & commercial payors
    d. Blueprint subsidizing Medicare portion
2. Community Care Teams (CCTs)
    a. Local multidisciplinary team
    b. Nurse coordinators, medical social workers, behavioral specialists, dieticians, and other health professionals
    c. Core resource providing care support for patients across participating practices for prevention, health maintenance, and chronic disease
    d. Guideline based on care coordination for individual patients
    e. Guideline based on population management
3. Community Activation and Prevention
    a. Public Health Prevention Specialist (PHPS) as part of CCT
    b. Integration of public health prevention and care delivery
    c. PHPS guides a systematic approach to community assessment, broad stakeholder engagement, consensus building, planning, and targeted intervention
4. Health Information Technology
    a. Web-based clinical tracking system (DocSite)
    b. DocSite produces visit planners and population reports
    c. Includes electronic prescribing

   d. Electronic Medical Records (EMRs) updated to match program goals and clinical measures in DocSite
   e. Health information exchange network to transmit data between EMRs, hospital data sources, and DocSite
5. Multi-Dimensional Evaluation
   a. NCQA-PCMH score (process quality)
   b. Clinical process measures
   c. Health status measures
   d. Claims-based health care patterns and expenditures (multi-insurer database)
   e. Claims-based return on investment and financial impact modeling

Successes:
Three pilot communities began BPIPP operations in July 2008. Evaluations are planned in order to determine the program's success, which is based on the following guidelines:
1. A sustained increase in practice adherence to NCQA-PCMH Standards.
2. An increase in the proportion of patients that receive guideline-recommended health maintenance and care for chronic conditions.
3. An increase in the proportion of patients that achieve improved control of their chronic health condition.
4. A shift from episodic to preventive patterns of health care and resource utilization.
5. A beneficial shift in total and/or marginal health care expenditures.
6. An improvement in the population indicators used to guide community activation and prevention.

Based on a financial model, the Blueprint expects to save $100 million over expected normal growth by 2013. Because this project is relatively new, financial savings have not been realized.

Challenges:
The Blueprint Integrated Pilots require multiple stakeholders to simultaneously initiate the broad and complex array of proposed reform efforts. Although steady progress is already being made, certain aspects of this reform effort remain particularly challenging:
1. Establishing a health information environment that supports the clinical goals of the program and meets the variable technical needs in different practice settings.
2. Variable understanding across stakeholders of the details and implications of this systems-based approach to health care reform.
3. Underlying implications of financial reform.
   All major insurers (except Medicare) are adopting a common approach to paying practices to deliver care in accordance with national standards for a patient-centered medical home and are also sharing the costs for community care teams. The financial rationale for investing in this prevention-oriented model is improved care that leads to a reduction in health care expenditures for poorly controlled disease. This is most likely to come in the form of reduced expenditures for unnecessary procedures, hospitalizations, and emergency room visits. Hospital budgets, in their current form, could be adversely impacted if the model is effective clinically and financially. Currently, there is no clear plan in place for hospitals to maintain the capacity to deliver essential acute care services while adapting to a financial environment that supports high quality out-patient preventive care.
4. Evolving effective collaboration between public health and health care delivery.
5. Engaging Medicare as a participant in multi-insurer health care reform.

Funding:
Medicaid and private payors participate in Blueprint for Health, and reimburse providers based on their NCQA-PCMH score. Grants established by the legislature are available in communities to support the work of Blueprint for Health, designed specifically to implement comprehensive community health and wellness projects to promote healthy behavior and disease prevention across the community and across the lifespan. The project office receives funds from Global Commitment, Catamount Fund, and Federal funds.

Sources: Annual Report - **http://healthvermont.gov/admin/legislature/documents/BlueprintAnnualReport0109.pdf**;
Program Website -**http://healthvermont.gov/blueprint.aspx**;
"Patient-Centered Medical Home and Health Care Reform: The Vermont Blueprint Integrated Pilots", PowerPoint presentation by Lisa Dulsky Watkins, MD, World Congress Executive Forum, December 2-3, 2008