**Qualitative Evaluation of
Provider and Practice Staff &
Blueprint-Related Team Members
and
Patient Perceptions
Related to Adoption of the Blueprint for Health
In Two Vermont Communities**

to
The Department of Vermont Health Access

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EXECUTIVE SUMMARY

The Vermont Blueprint for Health is a public health project that aims to improve medical outcomes for Vermonters. An on-going component of the Vermont Child Health Improvement Program's (VCHIP) evaluation of the Blueprint is continued exploration and understanding of its influence on advancing an integrated health services (IHS) model in the primary care practice setting. Provider and practice staff perceptions of healthcare transformations continue to be important to the Blueprint's growth and development. Equally important is to capture perceptions from community health and Blueprint-related team members who are playing pivotal roles in the development and implementation of the Blueprint model of care. Collecting data from individual patients served by Blueprint practices is an additional perspective from which to understand primary care practices (PCPs) advancement to patient-centered medical homes.

To gather first-hand insight into changes occurring within the primary care practice setting, two Vermont Blueprint communities were studied: Mt. Ascutney/Windsor, who started working with the Blueprint in October 2006; and St. Albans, whose first practice was recognized as an Advanced Primary Care Practice (APCP) in February 2010. Practice providers and staff, and Blueprint-related team members, as well as patients of local providers were invited to share their experiences through a series of individual interviews. In the Mt. Ascutney/Windsor Health Service Area (HSA), a total of 5 interviews were held with providers, practice staff and members of the Community Health Team (CHT). In the St. Albans HSA, 11 interviews were conducted with providers, practice staff and others responsible for identifying community needs and coordinating Blueprint activities and infrastructure. At the time of interviews, a Blueprint supported CHT was not yet operating in the St. Albans community. Individual interviews with patients were also conducted with the goal of gathering information about their perceptions of changes in the delivery of healthcare services. A total of 22 patient interviews were completed: 8 with patients of the Mt. Ascutney Physicians Practice; and 14 with patients of various providers within the St. Albans HSA. A synopsis of interview findings is offered below.

Interviews with Provider, Practice Staff and Blueprint-Related Team Members
Mt. Ascutney
The Mt. Ascutney Physicians Practice first adopted Blueprint in October 2006 with a focus on development of a diabetes registry and checklist. Simultaneous participation in Institute of Healthcare Improvement (IHI) and Vermont Program for Quality in Health Care (VPQHC) learning collaboratives contributed to Blueprint's adoption and implementation in the Mt. Ascutney HSA. Other contributing factors included early adoption of an electronic medical record (EMR), leadership support, and education and assistance provided by the state. A steering committee continues to direct Blueprint related activities. In 2009 Blueprint grant funding assisted with development of a CHT at Mt. Ascutney. The CHT is made up of staff that provides care coordination, behavioral health services, health coaching, and patient education. Several of these services existed prior to CHT development and others are new to the practice. As of January 1, 2011 both Mt. Ascutney Physicians Practice and Ottauquechee Health Center (a satellite office) were acknowledged as Advanced Primary Care Practices (APCPs) with recognition as patient-centered medical homes (PCMHs).

Several challenges and barriers to Blueprint's adoption and implementation were voiced. Most frequently mentioned is the operating culture within the practice. Providers are described as competent, independent practitioners. There is reported physician resistance and skepticism to meet all of the Blueprint recommended activities related to standardization of practice using evidence-based guidelines. Confusion related to roles and responsibilities also appears to be a factor, in that providers are trained to maintain responsibility for their patients' care. Another

reported barrier was the perception that panel management became a performance measurement tool that reflected poorly upon practice staff. Another participant spoke of healthcare transformation efforts as pushing providers towards becoming technicians rather than being the primary support of patient health. Provider skepticism about the validity of the diabetes data, first collected during the early years of Blueprint's adoption, was frequently reported by those interviewed. Organizational culture also seemed to be at play in that many talked about a lack of communication between CHT members, providers and practice staff.

Several strengths resulting from Blueprint adoption and implementation included positive changes in practice workflow and operations, and expansion of the CHT membership. Another reported strength is Blueprint's role in providing financial resources to augment programming for patients, such as the Wellness Recovery Action Plan (WRAP) program, Healthier Living Workshops, and tobacco cessation education programs. A strength related to Blueprint's development in Mt. Ascutney has been re-organization of the patient visit into a "planned visit". Nursing staff now "huddle" and plan in advance of patients' visits their needs for documentation and referral follow-up. The CHT was reported as another strength of the Blueprint model of care, in that patient needs and issues that otherwise would not be, were now being addressed.

Continued challenges include prevailing payment structures that continue to create a tension between the fee-for-service model, which is based on quantity, and the time intensive provision of care management services within the medical home (quality). Some also spoke of the need for sufficient data that demonstrates the Blueprint model actually delivers care at a reduced cost, while simultaneously improving patient outcomes. In the absence of this type of analysis there was said to be limitations in convincing many physicians of the APCP's utility. Seeking ways to effectively integrate CHT members and their corresponding roles into clinic operations continues to be a challenge. Reported concerns also were related to the accuracy and ability to extract data from DocSite. Those interviewed raised several future expectations for the Blueprint model of care and overall healthcare transformation efforts. Some discussed hopes that NCQA standards will help improve the organizational culture, promote teaming and demonstrate the utility of the CHT model of care.

St. Albans
Since 2003 the regional hospital, Northwest Medical Center (NMC) has operated a chronic disease management unit and made available diabetes education, Healthier Living Workshops, cardiac rehabilitation and tobacco cessation programming. Blueprint adoption and the onset of grant funding started in Fall 2010. Similar to Mt. Ascutney, several providers from the St. Albans community had previously participated in VPQHC collaboratives. With support from NMC leadership, in January 2010, chronic disease management staff facilitated and coordinated community stakeholder meetings to begin preparation for Blueprint adoption. A broad array of community members were included in early discussions, in which Blueprint leadership was present and offered suggestions for readiness, planning and implementation. The presence and availability of Blueprint leadership was reportedly instrumental in gaining sufficient buy-in and maintaining on-going momentum for the project.

At the time of interviews, the following practices had been recognized as APCPs: Mara Vijups, M.D. as of February 1, 2011; Franklin County Pediatrics as of March 1, 2011; and, Cold Hollow Family Practice as of May 1, 2011. Additional practices to be APCP recognized are: St. Albans Primary Care, Fall/Winter 2011; Northern Tier Centers for Health (NOTCH) Clinic, Fall 2011; and Mousetrap Pediatrics, Spring 2012.

Many factors contributed to St. Albans readiness for Blueprint adoption. Most frequently discussed was the collaborative nature of the St. Albans community and its providers. NMC staffing and leadership support for Blueprint-related activities, prior to and following Blueprint's adoption further spurred community commitment for the project. Recognition that the existing model of care, which is fragmented and primarily operates in "silos" was also mentioned as a key contributor to the community's readiness for change. Lastly, prior practice and NMC involvement with other quality improvement initiatives, such as VPQHC, provided the impetus for on-going adoption of the medical home concept.

Several barriers to the adoption and implementation of Blueprint were discussed. Generally, communication was reported most frequently as an impediment to the project's advancement in the St. Albans community. Also discussed most often was the current healthcare system's fee-for-service payment model, which provides incentives for the quantity, not necessarily the quality of care. The substantial time and resources necessary to become APCP recognized were reported by many and some questioned the financial viability of offering enhanced care according to the APCP-Patient Centered Medical Home (PCMH) model. Several others reported disappointment in other providers' lack of interest in becoming involved in the Blueprint.

Numerous strengths related to Blueprint, and the overall transformation of the healthcare system were mentioned. Efforts to transition the system from one that rewards only quantity to now recognize the importance of quality was often discussed. Several quality improvement initiatives resulting from Blueprint's adoption were said to be taking place within the St. Albans HSA. Several interview participants were also excited about having the ability to use evidence-based practice guidelines and focus on preventive rather than episodic care. Blueprint's ability to "force collaboration" among previously siloed practices, the hospital and community organizations now meant these entities had a reason and forum for improving communication and coordination. Panel management and referral tracking tools advocated by Blueprint assisted with creating feedback loops within primary care practices that previously did not exist. Other examples of Blueprint's benefit to healthcare reform and practice improvement efforts included sharing of expertise in the training of local provider staff.

Also discussed were several challenges related to Blueprint's implementation, and the overall transformation of the healthcare delivery system. In terms of implementation activities, a reported challenge to transitioning PCP's to APCP's was the ambiguity and inconsistency in some of the communication provided by state-level Blueprint staff. Other challenges discussed included: determining how best to staff the local CHT; the EMR's role in transformation efforts; the viability and financial stability of self-management approaches; referral communication feedback loops; and data barriers. Several mentioned a lack of follow-up information from referrals to other providers, especially from specialists in certain departments within a local hospital. DocSite was also described as an imperfect system that appeared to experience data reporting inaccuracies.

Several participants indicated that the St. Albans community has been implementing Blueprint according to Blueprint state-level staff and leadership recommendations. Blueprint is said to be forcing accountability to patients, among providers and within CHTs. Most participants reported that the Blueprint is still evolving and as of yet, not fully implemented or operating in the community. Currently, there are three committees or workgroups, facilitated by the Blueprint Project Manager, that are operating in St. Albans: Steering Committee, Clinical workgroup, and I/T workgroup. A sub-group of the clinical workgroup, the "Transitions in Care Process

Improvement Team", recently formed to address the discharge planning needs between NMC and local providers.

There is a reported "catch-22" between the work necessary for NCQA scoring and the delay in receiving enhanced reimbursements for services. Preparation for NCQA survey submission is time consuming and labor intensive. Most frequently discussed changes in practice workflow and operations were APCPs redesign of visit documentation and other NCQA standards to support evidence-based guidelines and patient self-management. Other reported changes included modifications in scheduling, messaging, prescription refills, patient rooming, self-management support and visit documentation. As a result, wait times have been reduced and phone messaging has been improved. Several practices spoke about now offering patient summaries (based on the office visit) and medication lists that support patient education and self-management. Others spoke about improved tracking processes for patient referral and lab result documentation.

Future expectations included hopes that additional practices would join the Blueprint model of care and become APCP recognized. Many reported that Blueprint supported other healthcare transformation efforts and incentives such as meaningful use and payment reform. Many talked of the important role provided by the project manager, practice facilitator and practice coach. Several raised concerns about the sustainability and staffing model of the CHT.

Individual Interviews with Patients / Blueprint Medical Home Consumers of Healthcare
<u>Mt. Ascutney & St. Albans</u>
Interviews were conducted with 20 patients of primary care providers (PCPs) and parents of 2 patients of a pediatric practice. Most participants had long-standing relationships with their physicians, many of whom had been a patient of the same provider for more than fifteen years. Reported chronic health conditions varied, with a majority of the 20 patients experiencing diabetes, high blood pressure, high cholesterol, and cardiac issues. For these patients, a myriad of other conditions was often present. Fewer reported anxiety and/or depression, and arthritis. The two other interviews were conducted with parents of children who received well-child care from a pediatrician. A majority of participants see the same provider at each visit, which is a reported change in one of the most recently recognized APCPs.

Addition of the electronic medical record (EMR) was most frequently discussed as the primary change in practice operations. Some described the "thoroughness" of the visit now that doctors appeared to ask questions based upon information contained within the EMR. Patient summaries, where and when offered, helped encourage patients to track their progress and be better informed about their health. Access to specialty care was favorable and said to be nearly always arranged by the provider. In most instances, good coordination between PCPs and specialists was reported to occur.

Nearly all of the patients interviewed reported they enjoyed favorable relationships with their providers. Questions were easily asked and a patient/doctor dialogue seemed to consistently take place during office visits. Most felt they were well-informed about their conditions and treatment plans. While a majority of patients discussed awareness of what needed to be done to manage their chronic conditions, barriers to actually implementing recommendations sometimes precluded follow-through. Most indicated they were compliant with medication management. However, challenges with following recommended diet and exercise routines were frequently described. Several discussed challenges to exercise because of past conditions.

Mt. Ascutney patients described positive interactions with members of the CHT that has been operating there since January 2010. In St. Albans, several spoke of the benefit received from participation in Healthier Living Workshops and/or diabetes education classes.

Key Findings
Several key findings from interviews with practice provider and staff, and Blueprint-related team members include:
- The work required to achieve APCP recognition is time consuming and labor intensive, and best facilitated in practices which have an operating EMR.
- Blueprint's transformation efforts align well with other initiatives such as meaningful use and healthcare payment reform.
- The practice facilitator role supports practices with implementation of self-management approaches and techniques, as well as preparation for NCQA recognition.
- CHT development and integration within practice settings can be challenging.
- Payment and incentive models continually need to be evaluated and updated to assure quality and holistic supports are available to patients.

Several key findings from interviews with patient / Blueprint medical home consumers of healthcare include:
- Consumers of healthcare services primarily attribute changes in practice to EMR usage.
- Patient perspectives reflect transformation within primary care practices are progressing as evidenced by: Improved access to providers, specialty care and community supports (e.g. access to insurance, availability of diabetic management supplies and testing equipment), opportunities for education in self-management and care of chronic conditions, and access to coordinated care.
- Despite awareness of self-management techniques, changes in habitual behaviors and control of one's desires are not necessarily easy to achieve.

Summary
A primary goal of the practice provider and staff, and Blueprint-related team member interviews was to identify experiences and reflections related to adoption of the Blueprint model, satisfaction with current activities and expectations for the future. As the Blueprint moves towards statewide adoption in 2011, an analysis of developments within an APCP setting are important in further understanding the Blueprints' strengths, accomplishments, and challenges. In addition, individual interviews with patients were conducted with the goal of gathering information about their perceptions of changes in the delivery of health care services.

This report achieves the above goals and demonstrates Blueprint's progress and on-going evolution in Vermont. Indicators of success, challenges and opportunities related to Blueprint adoption within the Mt. Ascutney and St. Albans communities is hoped to assist other providers in the state as they move towards APCP-PCMH recognition. Continued monitoring of patient experiences within the primary care practice setting and plans to systematically measure, on a larger scale, patient perceptions is advisable. In addition, on-going monitoring of APCP improvements and changes will inform future advances in healthcare reform efforts.

Report on Qualitative Evaluation of
Provider and Practice Staff & Blueprint-Related Team Members and Patient Perceptions
Related to Adoption of the Blueprint for Health in Two Vermont Communities

INTRODUCTION

The Vermont Blueprint for Health is a public health project that aims to improve medical outcomes for Vermonters. To better understand the Blueprint's impact on primary care, the Vermont Child Health Improvement Program (VCHIP), a research and quality improvement program in the University of Vermont's College of Medicine, has been evaluating the provider practice and similar components of the Blueprint since March 2007. Along with analysis of healthcare delivery systems, processes, and patient health status, and surveys of practice chronic illness and self-management support, previous evaluation activities have included discussions with project managers, providers and staff from primary care practices, Community Health Teams (CHTs), consumers of health care services, and other key informants involved with development, piloting and implementation of the Blueprint model of care.

An on-going component of VCHIP's evaluation is continued exploration and understanding of the Blueprint's influence on advancing an integrated health services (IHS) model in the primary care practice setting. Provider and practice staff perceptions of healthcare transformations continue to be important to the Blueprint's growth and development. Equally important is to capture perceptions from community health and Blueprint-related team members who are playing pivotal roles in the development and implementation of the Blueprint model of care. Finally, collecting data from individual patients served by Blueprint practices is an additional perspective from which to understand primary care practices (PCPs) advancement to patient-centered medical homes.

To gather first-hand insight into changes occurring within the primary care practice setting, two Vermont Blueprint communities were studied: Mt. Ascutney/Windsor, who started working with the Blueprint in October 2006; and St. Albans, whose first practice was recognized as an Advanced Primary Care Practice (APCP) in February 2010. Practice providers and staff, and Blueprint-related team members, as well as patients of local providers were invited to share their experiences through a series of individual interviews.

A primary goal of the practice provider and staff, and Blueprint-related team member interviews was to identify experiences and reflections related to adoption of the Blueprint model, satisfaction with current activities and expectations for the future. As the Blueprint moves towards statewide adoption in 2011, an analysis of developments within an APCP setting are important in further understanding the Blueprints' strengths, accomplishments, and challenges.

In the Mt. Ascutney/Windsor Health Service Area (HSA), a total of 5 interviews were held with providers, practice staff and members of the CHT. In the St. Albans HSA, 11 interviews were conducted with providers, practice staff and others responsible for identifying community needs and coordinating Blueprint activities and infrastructure. At the time of interviews, a Blueprint supported CHT was not yet operating in the St. Albans community.

Individual interviews with patients were also conducted with the goal of gathering information about their perceptions of changes in the delivery of health care services. Questions asked of patients, or Blueprint medical home consumers of healthcare, focused on access to care,

coordination of care, self-management and perceptions of overall health. A total of 22 patient interviews were completed: 8 with patients of the Mt. Ascutney Physicians Practice; and 14 with patients of various providers within the St. Albans HSA.

In collaboration with experienced qualitative research methodologists, VCHIP developed a series of questions to guide the individual interviews included in the 2011 qualitative assessment (see Appendix A for the healthcare providers recruitment strategy and discussion guide; Appendix B for the Blueprint medical home consumer of healthcare recruitment strategy, discussion guide and interview questions). These discussion guides were reviewed by Blueprint leadership and approved by the University of Vermont's Institutional Review Board (IRB) prior to commencing subject recruitment and enrollment activities.

Background and Context of the Blueprint Model of Care and Patient Centered Medical Home

Blueprint Model of Care
The Blueprint model of care continues to be a key contributor to health care transformation efforts in Vermont. Background information extracted from Blueprint's 2009 and 2010 annual reports provide context for understanding the Blueprint's goals, model and approach.

As described in the Vermont's Blueprint for Health 2009 Annual Report:
"Vermont's Blueprint for Health is guiding a statewide systems based approach to reform health services. As an agent of change, the Blueprint program is designed to:
- Implement a model that improves access to well coordinated preventive health services, centered on the needs of patients and families.
- Establish a functional continuum of services across sectors that are commonly not well integrated (e.g. healthcare delivery, mental health & substance abuse services, social & economic services, public health services).
- Guide multi insurer payment reform that supports a well integrated approach to preventive health services, while reducing barriers for patients and families.
- Improve the rate that the general population receives recommended health assessments, adheres with preventive therapies, adapts effective self management skills, and engages in healthy lifestyles.
- Reduce avoidable complications from chronic conditions through improved disease control and prevention, and coordinated access to the range of support services that target common contributors to poorly controlled disease.
- Reduce the rate at which healthcare costs are growing and demonstrate financial sustainability thru multi-insurer payment reform and a public-private partnership that results in;
  o An investment in the human and technical infrastructure that is necessary for preventive health services to be delivered effectively
  o A shift in current healthcare expenditures to support local Community Health Teams instead of contracted disease management services and call centers.
  o A reduction in healthcare expenditures associated with avoidable hospitalizations and emergency care.
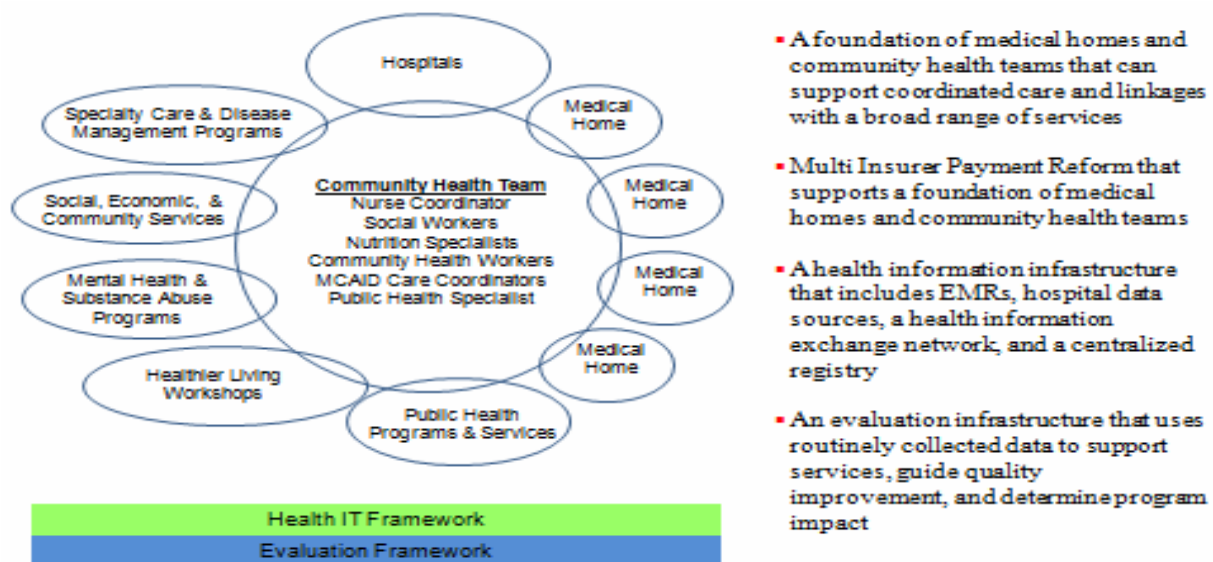
Advanced Model of Primary Care and Integrated Health Services:
The Blueprint Integrated Health Services (IHS) model provides a general population in a community access to guideline based preventive healthcare, and establishes a functional

continuum so that patients and families have well coordinated access to additional social, economic, and health related services as necessary. The model is based on several key components including;

- A foundation of Patient Centered Medical Homes (PCMHs) and Community Health Teams (CHTs).
- Multi insurer payment reform designed to support a foundation of Medical Homes and CHTs, and to incent guideline based well coordinated preventive care.
- A systematic and sustainable approach to improving self management that is embedded in the foundation of medical homes and community health teams, and extends to community based and specialty care programs.
- An information technology infrastructure that supports a community oriented continuum of services, enhanced self management and decision making, and contribute to meeting national standards for the meaningful use of health information.
- An evaluation and reporting infrastructure that utilizes routinely populated data sources, and provides ready access to information that can evaluate program impact and guide ongoing quality improvement." [1]

Blueprint Integrated Health Services Model - Figure from 2009 Annual Report.

Vermont Blueprint for Health, 2009 Annual Report[2]

In addition, recent legislation supported Blueprint's statewide expansion as reported in the Vermont Blueprint for Health 2010 Annual Report:
"Significant changes included the enactment of Act 128 in May 2010 by the Vermont General Assembly. The Act mandates the statewide expansion of Blueprint Integrated Health Services (IHS) – a model that includes Advanced Primary Care Practices (APCPs) with recognition as patient-centered medical homes (PCMHs) and community health teams (CHTs), supported by multi-insurer payment reforms. In order to continue serving Vermonters, all major insurers must participate in this model as it is expanded statewide. Evidence of this expansion requires a minimum of two primary care practices in each health service area (HSA) becoming APCPs by

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[1] Vermont Blueprint for Health, 2009 Annual Report, January 2010, pp. 5 – 6.
[2] Vermont Blueprint for Health, 2009 Annual Report, January 2010, p. 6.

July 2011. The Act requires the involvement of all willing primary care providers in Vermont by October 2013 (full statewide spread)."[3]

Patient-Centered Medical Home
The patient-centered medical home is a central concept within Blueprint's framework. The Agency for Healthcare Research and Quality (AHRQ), part of the U.S. Department of Health and Human Services, defines a medical home "not simply as a place but as a model of the organization of primary care that delivers the core functions of primary health care.
The medical home encompasses five functions and attributes:
- Patient-centered: The primary care medical home provides primary health care that is relationship-based with an orientation toward the whole person. Partnering with patients and their families requires understanding and respecting each patient's unique needs, culture, values, and preferences. The medical home practice actively supports patients in learning to manage and organize their own care at the level the patient chooses. Recognizing that patients and families are core members of the care team, medical home practices ensure that they are fully informed partners in establishing care plans.
- Comprehensive care: The primary care medical home is accountable for meeting the large majority of each patient's physical and mental health care needs, including prevention and wellness, acute care, and chronic care. Providing comprehensive care requires a team of care providers. This team might include physicians, advanced practice nurses, physician assistants, nurses, pharmacists, nutritionists, social workers, educators, and care coordinators. Although some medical home practices may bring together large and diverse teams of care providers to meet the needs of their patients, many others, including smaller practices, will build virtual teams linking themselves and their patients to providers and services in their communities.
- Coordinated care: The primary care medical home coordinates care across all elements of the broader health care system, including specialty care, hospitals, home health care, and community services and supports. Such coordination is particularly critical during transitions between sites of care, such as when patients are being discharged from the hospital. Medical home practices also excel at building clear and open communication among patients and families, the medical home, and members of the broader care team.
- Superb access to care: The primary care medical home delivers accessible services with shorter waiting times for urgent needs, enhanced in-person hours, around-the-clock telephone or electronic access to a member of the care team, and alternative methods of communication such as email and telephone care. The medical home practice is responsive to patients' preferences regarding access.
- A systems-based approach to quality and safety: The primary care medical home demonstrates a commitment to quality and quality improvement by ongoing engagement in activities such as using evidence-based medicine and clinical decision-support tools to guide shared decision making with patients and families, engaging in performance measurement and improvement, measuring and responding to patient experiences and patient satisfaction, and practicing population health management. Sharing robust quality and safety data and improvement activities publicly is also an important marker of a system-level commitment to quality." [4]

Furthermore, the National Committee for Quality Assurance (NCQA) is a national non-profit organization that seeks to improve the quality of healthcare services. NCQA has a recognition program that utilizes a standards-based process and scoring methodology to recognize APCPs

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[3] Vermont Blueprint for Health, 2010 Annual Report, January 2011, p. 3.
[4] http://www.pcmh.ahrq.gov/portal/server.pt/community/pcmh__home/1483/what_is_pcmh_

as PCMHs. As defined by NCQA, "A patient-centered medical home is a model of care that strengthens the clinician-patient relationship by replacing episodic care with coordinated care and a long-term healing relationship. Each patient has a relationship with a primary care clinician who leads a team that takes collective responsibility for patient care, providing for the patient's health care needs and arranging for appropriate care with other qualified clinicians. The medical home is intended to result in more personalized, coordinated, effective and efficient care." [5]

Also central to Blueprint's model is to align payment mechanisms that offer enhanced reimbursement for the care of patients. NCQA recognition includes a scoring process that supports additional remuneration for primary care and pediatric practices based upon the quality, not necessarily the quantity, of care provided. Transforming primary care practice to patient-centered medical homes involves, among other things, shifting the health care delivery system from one that only rewards fee-for-service transactions to one that also encourages improvements in health outcomes, while simultaneously containing costs. A recent national demonstration project indicates that APCPs' transformation efforts can be lengthy and complex.[6]

METHODS

Individual Interviews

Interviews with Provider, Practice Staff and Blueprint-Related Team Members

During May and June of 2011 VCHIP conducted individual interviews with the Mt. Ascutney / Windsor and St. Albans HSAs to gauge provider and practice staff, BP-related team members perceptions related to the model's adoption and implementation. Interview lengths ranged from 40 – 60 minutes and were held in provider and hospital locations. Potential interview participants were identified through existing practice lists and with assistance from local Blueprint project managers and provider practice managers.

Efforts to include participants with different levels of Blueprint experience and engagement and with different roles in the model's development were successful. Interviews with longer-term members, who had been with the Blueprint since its origins in late 2006, included discussions with a primary care provider, project manager, CHT members and practice management. Recent adopter perspectives in the St. Albans HSA included interviews with primary care providers (PCPs), Blueprint project manager and practice facilitator, nurses, practice coach, practice managers, and receptionist. Participants' familiarity with the Blueprint varied, ranging from "physician champions" and core practice Blueprint team members to individuals who had a limited understanding of either the Blueprint's specific objectives or its influences on their community or practice.

In all, 17 individuals from 5 practices participated in the VCHIP interviews. As seen in Table 1 below, the number, specific occupations and participant roles in Blueprint varied among the two HSAs.

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[5] http://www.ncqa.org/Portals/0/Programs/Recognition/2011PCMHbrochure_web.pdf
[6] Nutting, P., Crabtree, B., Miller, W., Stange, K., Stewart, E., and Jaen, C., *Transforming Physician Practices to Patient-Centered Medical Homes: Lessons from the National Demonstration Project*, Health Affairs, 30, No. 3 (2011): 439-445*.*

Table 1: Interviews – Provider and Practice Staff, and Blueprint-Related Team Members

Participant's Role in Blueprint (BP)	Mt. Ascutney	St. Albans	Total
Primary Care Provider/Pediatrician	1	3	4
Nurse – RN/LPN		1	1
Practice Manager, Administration	1	4	5
BP Project Manager	1	1	2
BP Practice Facilitator		1	1
BP Practice Coach		1	1
CHT Care Coordinator	1		1
CHT Behavioral Health Specialist/Community Provider	1	1	2
Total	**5**	**12**	**17**
Number of Practices Represented	1	4	5

To maximize validity, all discussions were led by the same experienced evaluator. She used a semi-structured interview format; asking questions based on the discussion guide and probing for details and elaboration when appropriate. In return for their participation, individuals were eligible to receive a $25 honorarium.

Individual Interviews with Patients / Blueprint Medical Home Consumers of Healthcare

A trained qualitative consultant conducted interviews with patients or "consumers" of healthcare services in the Mt. Ascutney and St. Albans Blueprint communities. Interviews occurred during the months of May and June 2011 and were held in-person at various private meeting locations, generally within the provider practice or hospital setting. Each interview discussion lasted approximately forty-five minutes.

Recruitment efforts were conducted by initiating contact with local community Blueprint Project Managers, who then deferred the researchers to CHT local leadership and hospital support staff for enrollment of participants. CHT and related practice staffs were asked to identify and invite patients to participate in the study. Selection criteria for recruitment were distributed in advance of actual recruitment. Patients received $25 in compensation for their time and travel to the interview. Whenever possible, patients were interviewed following their regularly scheduled office visit.

Interviews followed a semi-structured format. The interviewer asked patients questions based on the discussion guide; posing follow-up questions and soliciting explanations when pertinent. Table 2 identifies that 11 men and 11 women across seven practices participated in this segment of the evaluation; not all practices had been APCP recognized at the time interviews were completed.

Table 2: Interview Participants – Patients / Blueprint Medical Home Consumers of Healthcare

	Mt. Ascutney	St. Albans	Total
Male Participants	7	4	11
Female Participants	1	10	11
Total Number of Participants	8	14	22
Number of Practices Represented	1	6	7

ANALYSIS

All interviews were audio-taped with participant consent. Resulting recordings were transcribed for analysis. Participants were assured that identifiable information shared during the course of the interviews would remain confidential. References to provider names and individuals have been stripped of identifiers in the findings. Further, gender neutral language (e.g. he/she, him/her), where appropriate, has been added to better assure anonymity in reporting. Transcribed interviews ranged from 6 to 18 pages in length. In all, 457 pages of text were reviewed, coded, and analyzed thematically using techniques commonly associated with qualitative research methods.[7, 8]

The detailed, time-intensive nature of qualitative work limits the number of perspectives that can be shared. The extent to which individuals included in this work represent the opinions of their peers or colleagues is unclear. Furthermore, the complexity of the issues discussed and the evolving nature of the Blueprint pose additional challenges to generalizing themes from one HSA to another.

FINDINGS

Findings from each segment of the qualitative evaluation are reported as: 1) Interviews with Provider, Practice Staff and Blueprint-Related Team Members; and, 2) Interviews with Patients / Blueprint Medical Home Consumers of Healthcare. The first interviews are reported by the two communities, Mt. Ascutney and St. Albans, which were included in this year's evaluation. Patient interviews are presented in the aggregate and represent findings from both communities.

Overarching themes are bolded and italicized for emphasis, and in some cases, indented for ease in reading the report. Interview participant quotes are italicized to differentiate the source of the material. Following a report of the findings, key findings and a summary are offered.

Interviews with Provider, Practice Staff and Blueprint-Related Team Members

Mt. Ascutney
Description of Blueprint's Evolution
The Blueprint model was first adopted in October 2006 at the Mt. Ascutney Physicians Practice, which is co-located and owned by the regional hospital. The practice's current physician staff includes seven internal medicine and two family practice providers, and four pediatricians. Initial Blueprint activities involved establishment of a diabetes registry. Incentives for completing data entry into the diabetes registry were provided to nursing staff as a method for supporting this early change in practice operations. A diabetes checklist was developed next, which eventually evolved into a prevention-focused chronic care check list that is now used during most patient visits. While developing the diabetes registry, Mt. Ascutney also participated in an Institute of Healthcare Improvement (IHI) collaborative related to reorganization of the patient visit. Blueprint was instrumental in creating a way for the practice to collect data for the IHI project and the ensuing changes made to the practice's "planned visit" process.

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[7] Patton, Michael Q. (2002). *Qualitative Research and Evaluation.* Thousand Oaks, CA: Sage.
[8] Miles, M. & Huberman, M. (1994). *Qualitative Data Analysis: An Expanded Sourcebook* (2nd ed.)*.* Thousand Oaks, CA: Sage.

Since 1995, the Mt. Ascutney Physicians Practice has received a grant from the Vermont Coalition of Clinics for the Uninsured for operation of a "free" clinic (aka Windsor Community Health Clinic). The clinic's coordinator assists patients with access to health insurance, short-term care and medication assistance. Prior to Blueprint's adoption, Mt. Ascutney Physicians Practice also employed a diabetes educator. A nutritionist joined the staff about the same time as initial involvement with Blueprint occurred. In 2009 Blueprint grant funding assisted with further development of the CHT at Mt. Ascutney. The free clinic's coordinator, diabetes educator, and nutritionist roles have been integrated into the team of CHT members that now support practice operations. Some members of the team, while included in CHT and Blueprint activities, are not necessarily funded by the Blueprint, as indicated in the table below.

Currently, the CHT membership includes:

Role Prior to Blueprint	Blueprint Community Health Team Role	Funding Source
Diabetes Educator	Diabetes Educator / RN Care Coordinator	.5 Blueprint
Nutritionist	Outpatient Dietician	Enhanced reimbursements
Free Clinic Coordinator	Community Support Coordinator	Enhanced reimbursements
	Behavior Health Specialist	Blueprint
	Social Worker, Community Care Coordinator	Blueprint
	Pediatric Case Manager	Rural Health Grant
	Health Coach	Blueprint
	DVHA, Senior Nurse Case Manager	DVHA

Blueprint stakeholders (originally practice manager, physician representative, project manager, practice secretary, and diabetes educator) met regularly until a rotational change in medical directors occurred. Under new medical direction in 2008, the strategies for patient care reportedly changed whereby practice physicians were to assure delivery of the health management components of care. A steering committee has continued to provide Blueprint direction and as of January 1, 2011 both the Mt. Ascutney Physicians Practice and Ottauquechee Health Center (a satellite office) were recognized as APCP-PCMHs. During the past several years the practice has added hypertension and coronary disease to its Blueprint list of clinically important conditions for NCQA purposes.

Factors Contributing to Blueprint's Adoption and Implementation
Prior participation in Vermont Program for Quality in Health Care (VPQHC) and IHI learning collaboratives provided a basis for conducting changes in practice workflow and movement towards practicing according to a medical home model of care. This was described by one person who said, "*the timing of our introduction to Blueprint flowed naturally and it helped in the evolution of where we were going, staring with the IHI work.*" Early adoption of an electronic medical record (EMR) in 2003 was also reportedly a key factor that aided in Blueprint's implementation. Access to panel management data, extracted as a result of Blueprint participation, supported quality improvement efforts within the practice. Many interview participants reported that Blueprint's adoption was also aided by the support of key leaders within the hospital and practice setting. Specifically, endorsement by the hospital's Chief Executive Officer was reported as pivotal to Blueprint's adoption and implementation. Support from nursing and I/T staff during this time was also reported as instrumental in advancing the practice towards becoming an APCP recognized practice. Another factor described as aiding with Blueprint's implementation was the education and support provided by the state. This assistance included conferences, collaborative trainings, and participation in project managers'

and care coordinators' conference calls. As one person indicated, "*the cross fertilization that takes place in those meetings, the preparation for learning the standards and being part of the collaboratives helped us to hear what was happening in other parts of the state.*"

Challenges and Barriers to Adoption and Implementation
Most frequently mentioned as a barrier to Blueprint's implementation is the operating culture within the practice. Providers are described as competent, independent practitioners. There is reported physician resistance and skepticism to meet all of the Blueprint recommended activities related to standardization of practice using evidence-based guidelines. The following description adeptly describes the complexity involved with Blueprint's adoption and implementation, and influence of the existing organizational culture within the provider practice:

> *"It is a very delicate process between trying to implement programs that are promoted at a statewide level that – and that have implications for physicians' practices. Because physicians are very much the captain of the ship. They very much need to direct their practices. This is a great group. They tend to be individualistic in their approach and so there's a tug and pull between standardization and individual practices. And that's a barrier. When you tell a physician that we want all our people with A1C's at 7. I mean they had a strong reaction to that. Show us the research. Show us why that makes a difference. And when the guidelines get ahead of the research, they know that, and so that's a barrier. There is also a tug and pull between standardization and best practices and an individual doctor-patient relationship. And that's I think one of the harder things. And also there's a little distrust of – who is this little Blueprint group that's working, and what the heck are they doing. So we're trying to really make that bridge stronger. And we continually work on doing the things that have to happen behind the scenes to make it easier to meet the standards without saying to the physicians, you have to do this, this, this, and this and this. So trying to understand that balance to help us move ahead without having them have to do extra work or even being involved with – you know, why should we be doing this kind of stuff? So what gets up front and what happens behind the scenes is another sort of tug and pull. So if you asked anybody – all of the providers, what is the Blueprint, I mean you'd get thousands of answers. And what is the NCQA standards? There was a core group of people that worked to prepare for the standards – but in general, if you were to ask them what are the standards and how do you live them out for the medical home, – you know, you would get thousands of different answers.*"

Confusion related to roles and responsibilities also appears to be a factor, in that providers are trained to maintain responsibility for their patients' care. The necessary trust and willingness to seemingly transfer this responsibility to others, such as to members of the CHT, may seem counter-intuitive to providers. Another reported barrier was the perception that panel management became a performance measurement tool that reflected poorly upon practice staff. As one person said, "*I think the doctors felt like somebody was breathing down their necks….when they got the reports and somebody said, you didn't do a good enough job. I think there was a perception that this was an audit of something rather than an aid.*" Another participant spoke of healthcare transformation efforts as pushing providers towards becoming technicians rather than being the primary support of patient health.

Provider resistance and skepticism about the validity of the diabetes data, first collected during the early years of Blueprint's adoption, was frequently reported by those interviewed. A physician in the practice apparently intervened to assure panel management reporting accurately reflected patient characteristics. As mentioned previously, another reported challenge was the Blueprint's initial focus on specific Hemoglobin A1C levels as a benchmark and indicator of health outcomes. Most physicians within the practice believed that blood

pressure and lipid levels were more important indicators in the management of diabetes and other chronic conditions. This stance was said to be representative of the independent culture operating within the practice.

Organizational culture also seemed to be at play in that many talked about a lack of communication between CHT members, providers and practice staff. This was indicated when a person said, "*the strategies changed to be based more on the clinician, the physician or nurse practitioner instead of a team approach.*" Furthermore, meetings within the practice were apparently held according to group specific roles, such that physicians, nurses and CHT members each met separately. This structure apparently limited opportunities for "cross-fertilization" of learning, and coordination between Blueprint-related staff and providers.

Blueprint Model's Strengths
Several strengths resulting from Blueprint adoption and implementation included positive changes in practice workflow and operations, and expansion of the CHT membership. Another reported strength is Blueprint's role in providing financial resources to augment programming for patients, such as the Wellness Recovery Action Plan (WRAP) program, Healthier Living Workshops, and tobacco cessation education programs. Panel management has also allowed the practice to evaluate patient health in the aggregate and implement strategies geared towards preventing long-term complications. The focus on self-management techniques and approaches contributes to providing supports that are holistic in nature and considerate of individuals' overall needs, not just those related to his/her medical condition. As one person stated, "*I think the strength [of the model] is that we're looking at the person as the whole person – and also a person that's more in charge of being able to make their choices regarding their care; a more informed patient as well.*"

Changes in Practice Workflow & Operations
A strength related to Blueprint's development in Mt. Ascutney has been re-organization of the patient visit into a "planned visit". Nursing staff now "huddle" and plan in advance patient visit needs for documentation and referral follow-up. Practice changes have been made as Blueprint has evolved in the practice. For instance, health maintenance worksheets are now completed on all patients. In addition, the diabetes checklist has been added to the practice's EMR. As one person stated,
> "*Well, it revolutionized the way we looked at patients and early in the Blueprint, we developed this diabetes checklist which now becomes sort of the chronic care checklist, which says, okay what do they need for preventative health, what do they need for labs, when was their last A1C – before the patient comes in so that they can gather the information, take a look at it when they have the patient in front of them. So it's an informed practitioner with the information that they need to really do some more teaching and goal setting with the patient.*"

Lastly, telephone system messaging and routing has been revamped to better support patient care.

Role of the Community Health Team
In 2009 the CHT at Mt. Ascutney Physicians Practice started operating. While diabetes education and access to "free-clinic" services had been available previously, Blueprint funding supported the addition of a behavioral health specialist and social work staff. The diabetes educator acts as the CHT Care Coordinator and is a registered nurse. This individual maintains responsibility for leading the team of CHT members and assuring patient care is coordinated. Weekly meetings among CHT members provide an opportunity to discuss patient needs and areas for improvement, such as review of hospital discharge data and potential methods for

improving linkages with practice providers. Some of those interviewed report that patients are not aware of the changes and benefits associated with access to members of the CHT. As one person interviewed stated, "*the patient does not necessarily know that the CHT looks like this and that we work together, per se. They are just seeing it as help to try to get all of their help issues addressed.*" Another person talked about the benefit of having accessible behavioral health services within the primary care practice setting, "*there are times when people just want to talk to someone….the doctors are on a tight time schedule and they can say, there's somebody here that you can talk to, are you interested?…..There are people that would not necessarily say, I need counseling, but yet they definitely want to talk over some things with someone.*"

Continued Challenges
Prevailing payment structures continue to create a tension between the fee-for-service model, which is based on quantity, and the time intensive provision of care management services within the medical home (quality). A person interviewed indicated that a provider would receive more money for completing procedures, such as freezing a wart, than completing chronic disease management for someone with diabetes. A reported bias in healthcare financing towards procedural work was reported as an on-going challenge to Blueprint implementation. Some also spoke of the need for sufficient data that demonstrates the Blueprint model actually delivers care at a reduced cost, while simultaneously improving patient outcomes. Without this analysis there was said to be limitations in convincing many physicians of the APCP's utility.

Seeking ways to effectively integrate CHT members and their corresponding roles into clinic operations continues to be a challenge. A limited number of referrals from providers is said to be potentially impacting patient access to CHT supports. Also mentioned are inconsistent referral patterns among providers who work in the practice. One person interviewed summarized the dynamic by stating, "*I feel like I am operating in a silo type of way……I think the CHT members are perceived as a threat…..A physician does not want another practitioner involved with his/her patient, some do not want another level of care in there.*" DocSite reporting has been inconsistent and limited in scope. Reported concerns related to the accuracy and ability to extract data from DocSite continues to be a challenge.

Expectations for the Future
Those interviewed raised several future expectations for the Blueprint model of care and overall healthcare transformation efforts. Some discussed hopes that NCQA standards will help improve the organizational culture, promote teaming and demonstrate the utility of the CHT model of care. A participant summarized this desire when he/she stated,

> "*We really don't play that well together. We don't really talk as a clinic. We talk individually. The nurses have their meeting. The secretaries have their meeting. The medical staff has their meeting. But not at any given time do we ever come together and talk as how a clinic operates or doesn't operate, or to list the strengths and improvements or what things we're going to put in the parking lot or, all of those things that are on a daily operational level, are not 100 percent working well. They can't be. There's got to be some little idiosyncrasies here and there. And so I think the NCQA as a recognition body, will see where those gaps and processes are, and because it's an outside agency actually looking at us, that when there are deficiencies, I feel that the clinical staff will probably listen to those opportunities in improvement more than it would from the Blueprint team coming up with some idea on how we could improve.*"

Another person described the promise of the CHT and said, "*When we work together, we can make a lot more headway than if it's just the doctor and nurse.*"

Other future expectations included implementation of a new EMR, which is anticipated for early 2012. The revised EMR will provide linkages between the hospital and Mt. Ascutney Physicians Practice. Additionally, a desire for payment reform was discussed. A person interviewed said,

> "*I think it does take time to offer really good care, and unfortunately with our compensation model – billings – the only way you get paid is to see more patients or to increase revenue is see more patients. So we very much are looking forward to the medical home and more of a capitated situation so that we can spend a little more time with the patient and not have to barrel through 3 or 4 just to get enough money to pay your staff at the end of the day.*"

Similarly, reforms within the insurance industry was also mentioned as indicated by the following example,

> "*So if I have a patient who's calling and can't get their medication because we can't figure out what part D plan they have or what's on their list and nobody knows what's on their list and the doctor doesn't know because our system doesn't talk to their list, and then if you get an MRI ordered and it's a little different issue over here, if you have this insurance, and it's a different criteria over here for this insurance – just all of [the differing criteria]. If it could just all be one criteria. I don't care that there's criteria. What drives me crazy is that it's different for everybody and coding is different.*"

Recommendations

Suggestions for improved healthcare delivery that were voiced among those interviewed include:

- Consider utilizing nursing staff differently as the APCP-PCMH model of care continues to develop.
- Strive for development of one standard criterion for coverage among all insurances, as indicated above.
- Create a universal tool for data management and reporting that easily elicits patient information.
- Allow physicians, rather than the insurance companies, to dictate what formularies can be prescribed to patients.
- Continue to address methods for improving synergy between provider and CHT staff.

St. Albans

Description of Blueprint's Evolution

Since 2003 the regional hospital, Northwest Medical Center (NMC) has operated a chronic disease management unit and made available diabetes education, Healthier Living Workshops, cardiac rehabilitation and tobacco cessation programming. In 2006 the St. Albans HSA originally applied, but were denied grant funding for Blueprint activities. During the summer of 2010 St. Albans submitted another grant funding request to support a .5 FTE project manager, practice facilitator and nurse coordinator position. Blueprint adoption and the onset of grant funding started in fall 2010. Similar to Mt. Ascutney, several providers from the St. Albans community had participated in VPQHC collaboratives, dating back to 2003. According to participants NMC was committed to providing support for Blueprint activities as it believed it was in the best interest of both the community and the patients it serves. NMC also recognized the vital link primary care played in the local continuum of care and wanted to work to sustain the existing network of providers.

With support from NMC leadership, in January 2010, chronic disease management staff facilitated and coordinated community stakeholder meetings to begin preparation for Blueprint adoption. NMC staff took a leadership role in inviting and coordinating early plenary meetings.

A broad array of community members were included in early discussions, in which Blueprint leadership was present and offered suggestions for readiness, planning and implementation. The presence and availability of Blueprint leadership was reportedly instrumental in gaining sufficient buy-in and maintaining on-going momentum for the project. As one participant said, "*Craig and/or Lisa [director and associate director of the Blueprint] came to at least the first 3 or 4 meetings – they really helped us build some momentum.*"

A core group of stakeholders have continued involvement with Blueprint and now serve on the Blueprint's Steering Committee. Initial efforts included completion of a needs assessment to inventory the current availability and gaps in services. In addition to the Steering Committee, an Information Technology (I/T) and Clinical Workgroup have formed. Many members of the steering committee also serve on the clinical and I/T workgroups. At the time of interviews, the following practices had been recognized as APCPs: Mara Vijups, M.D. as of February 1, 2011; Franklin County Pediatrics as of March 1, 2011; and, Cold Hollow Family Practice as of May 1, 2011. Additional practices to be APCP recognized are: St. Albans Primary Care, Fall/Winter 2011; Northern Tier Centers for Health (NOTCH) Clinic, Fall 2011; and Mousetrap Pediatrics, Spring 2012.

Factors Contributing to Blueprint Adoption
Many factors contributed to St. Albans readiness for Blueprint adoption. Most frequently discussed was the collaborative nature of the St. Albans community and its providers. NMC staffing and leadership support for Blueprint-related activities, prior to and following Blueprint's adoption further spurred community commitment for the project. Recognition that the existing model of care, which is fragmented and primarily operates in "silos" was also mentioned as a key contributor to the community's readiness for change. Lastly, prior practice and NMC involvement with other quality improvement initiatives, such as VPQHC, provided the impetus for on-going adoption of the medical home concept.

Nearly everyone interviewed spoke of the St. Albans community's collaborative spirit as a key factor that aided in Blueprint's adoption. One person summarized this when stating, "*I think the people are dedicated and that we all get it. We know why we're doing this work. And we all are approaching this with a collaborative philosophy that we're going to help each other out, as opposed to a competitive approach which has been in place in this area before.*" Another person interviewed shared, "*there's a natural working alignment. It's a good community where you can get a diversity of people sitting around a table working towards a cause…. you can really sit down and work together to make sure things are happening.*" Also often mentioned was the strong engagement of community partners towards assuring Blueprint's adoption and implementation.

In addition, NMC's ability to provide staffing and leadership support for the Blueprint was frequently discussed by those interviewed. Hospital participation and its role in facilitating, but not driving or directing the project was offered as a key component related to Blueprint's adoption. As one participant stated, "*[we would not participate in past initiatives] because it would clearly be about the hospital's bottom line and it would not engage us in the process, where [NMC] seems to finally recognize the importance of primary care and the changes in primary care that have to happen.*" In addition, many spoke of the pivotal role staff from NMC, namely the Blueprint practice facilitator, practice coach and project manager have played in facilitating the process and process improvement measures central to advancing primary care practices towards recognition as patient-centered medical homes.

Several people interviewed talked of a fragmented or "siloed" healthcare system as an impetus for initiating the Blueprint model of care. Many longed for a better coordinated, integrated system in which to deliver healthcare services. One person stated,

> "*there would be better reimbursement, but the bigger reason was wanting to help to coordinate health care in a bigger picture with the whole community health care teams with the understanding that there wouldn't be a duplication of services, but a common point person, for mental health services….or somebody who is very savvy to help coordinate the bigger picture; that all practices would be able to access.*"

Another discussed the realization that the system is fragmented and needs to change in order to deliver care that, for instance, integrates behavioral health while simultaneously supporting primary care providers. In regard to the payment mechanisms supporting Blueprint activities, and not being certain of their sustainability, one person indicated that the project in some ways requires a "leap of faith."

Participants from Mara Vijups, Cold Hollow and Richford's NOTCH practices reported that past VPQHC collaboratives were instrumental in creating a baseline understanding and commitment to the concept of a medical home. The NMC staff person, who is now charged with the Blueprint Project Manager role, was able to participate in VPQHC activities and had established pre-existing relationships with providers in advance of facilitating community adoption of the Blueprint. Past participation in other quality improvement activities reportedly supported readiness and adoption activities. Lastly, a factor mentioned by several of those interviewed was Blueprint's state-level leadership's aid in gaining sufficient buy-in for its adoption in the St. Albans community.

Barriers to Adoption and Implementation

Several barriers to the adoption and implementation of Blueprint were discussed. Generally, communication was reported most frequently as an impediment to the project's advancement in the St. Albans community. Also discussed most often was the current healthcare system's fee-for-service payment model, which provides incentives for the quantity, not necessarily the quality of care. The time and resources to become APCP recognized were reported by many and some questioned the financial viability of offering enhanced care according to the APCP-PCMH model. Several others reported disappointment in other providers' lack of interest in becoming involved in the Blueprint.

Communication barriers were reported most frequently as a challenge to the Blueprint's adoption and implementation. Mixed-messages received about the timing and availability of funding to support Blueprint adoption was mentioned on several occasions. In one case, a person indicated that local community members had been assured they would receive grant funding, but then received word during a statewide conference presentation that St. Albans was not slated to receive funding. Another person discussed a lack of recent communication about the project's evolution as a barrier to understanding on-going implementation plans.

Several spoke of messaging from state-level Blueprint staff that often seemed reactive. Requests for information reportedly would change, which created frustration among local Blueprint-related team members and practices. Local Blueprint representatives, acting as the facilitator between state Blueprint staff and local providers were sometimes placed in an uncomfortable position, needing to be the mediator of changing expectations and state-level requests for information. The local Blueprint-related team members were sympathetic to forwarding already overburdened practice staff state initiated demands for additional work products.

Many discussed a barrier to Blueprint adoption as being related to the existing model of payment for healthcare services. The fee-for-service environment, as one person indicated, supports "*just cranking through the numbers…..that driver does not drive for quality.*" This person stated further, "*the patient-centered medical home is very time intensive. It's very rewarding to do it, but the old system doesn't reward us for that…. It won't be sustainable unless the payment model changes.*" Another person summarized the existing payment structure and said,

> "*the barriers are the existing systems and processes of care…..how everybody gets paid. The alignment of incentives doesn't necessarily support some work, for example, weight management. If someone needs to understand nutrition so that they can lose weight, then we want to be able to have them work with a dietician. But the funding or the reimbursement for medical nutrition therapy is nonexistent for a diagnosis of obesity.*"

The significant amount of up-front time and resource commitments necessary to become an APCP were reported as a barrier, especially for small practices with limited resources. The large initial investment caused some practices to question whether the enhanced reimbursement levels would cover the cost of practicing care according to the APCP-PCMH model. A participant concerned about the CHT's sustainability said he/she believed that "*the [Blueprint] payment model does not adequately compensate even non-physician resources to provide the comprehensive kind of care that people with chronic conditions need.*"

Another barrier reported by a few participants was the challenge related to the fact that some entities (e.g. self-insured organizations) did not have to contribute to the incentives or increased reimbursement levels. Several other interview participants spoke of the disappointment that more providers were not participating in the Blueprint. Apparently, delays in the time between readiness and adoption of the Blueprint model of care caused some community providers to decide against Blueprint participation at this time.

Strengths and Challenges Related to Blueprint & Transformation of the Healthcare System
Numerous strengths related to Blueprint, and the overall transformation of the healthcare system were mentioned. Efforts to transition the system from one that rewards only quantity to now recognize the importance of quality was often discussed. Several quality improvement initiatives resulting from Blueprint's adoption were said to be taking place within the St. Albans HSA. For instance, approaches to stemming the high usage of NMC's Emergency Department (ED) were being considered among Blueprint community members. In addition, newly developed curriculums that offered training around opiate prescribing and working with patients with chronic pain was another of several quality improvement-related examples provided.

Several interview participants were also excited about having the ability to use evidence-based practice guidelines and focus on preventive rather than episodic care. One person referenced the stigma associated with seeking care for mental health issues and the Blueprint's ability to be prevention-based when he/she stated, "*it also helps with the stigma, frankly. That's our biggest challenge no matter where we are. We know what is nice about this model [Blueprint] is we are identifying people who wouldn't seek behavioral health assistance until things really got bad…..it has a prevention feel to it.*" Another participant spoke about payment reforms initiated by Blueprint as supporting a focus on "prevention type work." Department of Vermont Health Access (DVHA) case manager co-location in provider practices was also reportedly a beneficial and prevention-focused change in practice. For example, DVHA case managers' roles in "*proactively intervening to redirect [Medicaid eligible patients] to go to their primary care*

provider instead of the emergency department" was cited as a positive change resulting from Blueprint's adoption in this community.

Blueprint's ability to "force collaboration" among previously siloed practices, the hospital and community organizations now meant these entities had a reason and forum for improving communication and coordination. One person discussed this when he/she stated, "*I think Blueprint's actually forcing a lot of us to say, there have to be ways that we work together in different ways.*" Improved relationships between providers and NMC, as well as among practices was said to be occurring, in part due to Blueprint's entrée into the St. Albans community. One participant talked about hospital transitions of care and working to narrow the information and timing gaps associated with discharge planning, procedure scheduling and primary care follow-up. This person said,
> "*I think this is going to lead to all the participating Blueprint providers providing better service in the end because now we know what NMC needs in their ED or on an in-patient admission or a surgical procedure that's being scheduled. And they know what the PCP needs on the other end to make the transitions smoother.*"

Another person discussed how improved communication had resulted in streamlined resolution of issues between behavioral and medical health providers.

Panel management and referral tracking tools advocated by Blueprint assisted with creating feedback loops within primary care practices that previously did not exist. As one participant mentioned, "*the whole Blueprint activity has allowed us to be more informed about other linkages that we make with [and for] patients. We have an improved method for following them.*" He/she went on to state, "*we're able to keep a closer eye on them, but I don't know if they realize that we are [tracking them differently].*"

Other examples of Blueprint's benefit to healthcare reform and practice improvement efforts included sharing of expertise in the training of local provider staff. NMC offered motivational interview technique training to local nursing staff who could then deliver self-management support to their patients. Another example of shared expertise included training for local providers in tobacco cessation and education. One person described the importance of sharing skills and expertise when he/she said, "*it's about making sure that the people that need the services have access to them when needed, and the best way to do that is to make sure that people on the front lines have the skills themselves.*"

Also discussed were several challenges related to Blueprint's implementation, and the overall transformation of the healthcare delivery system. In terms of implementation activities, a reported challenge to transitioning PCPs to APCPs was the ambiguity and inconsistency in some of the communication provided by state-level Blueprint staff. For instance, several spoke of difficulty in gaining clear direction about the list of pediatric conditions that would be considered for NCQA recognition. As one participant indicated, "*I don't think Blueprint was really ready for a pediatric practice, they had no important conditions to give us.*" Another example of communication challenges related to the difficulty in relaying changing needs and expectations between Blueprint-related team members and the APCPs. One also spoke of frustration that some state-level coordinated conference call meetings were not well-publicized, and did not start according to schedule.

Communication challenges among Blueprint-related team members were also described as an implementation barrier. Some talked of an apparent need to improve communication between project managers and practice facilitators across the state. While these roles shared a positive

working relationship locally, additional direction from the state related to the blending and integration of these functions was thought to potentially benefit others.

Other challenges discussed included: staffing the local CHT; the EMR's role in transformation efforts; the viability and financial stability of self-management approaches; referral communication feedback loops; and data barriers. Many talked of the challenges related to setting up, implementing and sustaining the CHT. The need for gaining group consensus about CHT staffing roles and responsibilities was reportedly time consuming. Sustainability of CHT members and best approaches for integrating behavioral health, without duplicating services, were of concern to several of those interviewed. A desire to build self-management approaches within practices, rather than assigning this component to the CHT was thought to best assure the model's future sustainability.

One participant spoke about the relative "newness" of the EMR and its limited availability in some practices as a challenge to on-going healthcare transformation efforts. Another person talked of healthcare consumers' lack of sophistication and questioned the impact this might have on the overall movement towards advancing primary care and integrating self-management standards into the model's design. This person said,

> "*there's so much that patients don't know what they should be doing. And in the past physicians, nurse practitioners, nurses have said, well it is not our fault. It's not our fault that McDonald's is out there pushing billions of hamburgers which make people sick. It's not our fault that Philip Morris is pushing cigarettes that make people sick. There is a role for primary care and frankly, any provider to play in it. But there's [little] compensation and patients don't want to pay to be told they can't do the things they like to do. So there seems to be a disconnect on all levels. There's a lot of dissonance in the system. And it seems to fall on the medical home to patch up the holes. And then PCPs are still not getting adequately compensated.*"

Several mentioned a lack of follow-up information from referrals to other providers, especially from specialists in certain departments within a local hospital. Lastly, DocSite was described as an imperfect system that had some data reporting inaccuracies.

Current Status of the Blueprint
Several participants indicated that the St. Albans community has been implementing Blueprint according to Blueprint state-level staff and leadership recommendations. Blueprint is said to be forcing accountability to patients, among providers and within CHTs. Most participants reported that the Blueprint is still evolving and as of yet, not fully implemented or operating in the community. As one person said, "*There is a lot of great interest, a lot of great discussion, but [the Blueprint] is still in its very, very first stages.*" A majority of those interviewed indicated that formation and execution of the CHT is the point at which Blueprint's implementation will be realized.

Role of Committees and Workgroups
Currently, there are three operating committees or workgroups, which are facilitated by the Blueprint Project Manager: Steering Committee, Clinical workgroup, and I/T workgroup. The Steering Committee presently has representation from three adult/family primary care and one pediatric practice, a practice facilitator, home health, mental health, DVHA case management, Vermont Department of Health (VDH) Alcohol and Drug Abuse Program, and VDH Community Health leadership. Most steering committee members also participate in the Clinical Workgroup, which supports practice improvement efforts and is responsible for development of the CHT. Meetings are held monthly, during evening hours (dinner is supplied) to accommodate physician schedules. As one person stated, "*if you want to have the primary care*

providers engaged, you have to make sure that [meeting times] are conducive to their schedule." Agendas and meeting minutes are prepared and information is shared through a list serve. A sub-group of the clinical workgroup, the "Transitions in Care Process Improvement Team", recently formed to address the discharge planning needs between NMC and local providers, and "*improve transitions from hospital to home so that patients don't land back in the hospital or emergency department.*" This person further indicated how the group's work was not necessarily in the hospital's best financial interest and how misaligned incentives within the healthcare system seemed to be working at "cross purposes." Lastly, the I/T Workgroup s working to develop methods for connecting PCPs and related agencies in the health information exchange.

NCQA Scoring and Recognition

There is a reported "catch-22" between the work necessary for NCQA scoring and the delay in receiving enhanced reimbursements for services. Preparation for NCQA survey submission is time consuming and labor intensive. A participant from one practice described that many steps had to be completed as part of his/her practice's transformation to an APCP and suggested that practices should plan to take two years to prepare for NCQA submission. Short timelines between notification and actual scoring were mentioned by several interview participants as a challenge. A person described the process by stating, "*it was a bit of a sit around waiting and then all of a sudden, boom, boom, boom. We had to be ready, and we felt that there was not a lot of appreciation for how much work goes into preparing one of these applications.*" Assistance from VCHIP in the scoring methodology was helpful; NCQA terminology was often not well-understood and having a local resource available for guidance was instrumental in being able to complete the process. Coaches made available by NMC were also reported as a helpful resource. Without this assistance, several questioned how providers - especially small practices, would be able to successfully complete the process. A few of those interviewed discussed that they thought the NCQA standards were beneficial in providing a road map and future direction for healthcare practices to follow. As one participant indicated, "*[the NCQA process] forced us to an organized way on a checklist approach, go through our work flow and make sure it was a good as we thought.*"

Changes in Practice Workflow & Operations

Most frequently discussed changes in practice workflow and operations were APCPs redesign of visit documentation and other NCQA standards to support evidence-based guidelines and patient self-management. A participant summarized this when he/she stated, "*some of the practices have done great improvement work with modifying their electronic records to support evidence-based care and self-management. That is something where I have seen great progress.*" Other changes in workflow and operations included modifications in scheduling, messaging, prescription refills, patient rooming, self-management support and visit documentation. Positive outcomes were reported, such as reduced wait times and improved phone messaging tracking. Several practices spoke about now offering patient summaries (based on the office visit) and medication lists that supported patient education and self-management. Others spoke about improved tracking processes for patient referral and lab result documentation. One person discussed changes in the way EMR data is entered to support the generation of reports that help manage patient health based on evidenced-based guidelines. This individual said, "*I've now learned how to [enter the data in the EMR] so we can run a report and see who is due for mammograms, colonoscopies, etc.*"

One practice talked of experimenting with adding the role of scribe to assist a physician with EMR data entry and documentation during the patient visit. The person described this change and said,

"Our office visits are longer now [because of the EMR]. From a provider standpoint, I hear from them that they feel like data entry clerks; they used to dictate at the end of the visit and the rest of the time, it was hands-on, face-to-face……One provider now routinely works with a scribe…..if you look at it strictly from hours spent, it's probably less efficient, but when you can show an increase in the amount of patients that provider can see, I think it actually pays for itself."

While all the other PCPs did not have the luxury of adding new staff, some were reportedly using staff differently. For instance, medical assistants were said to now have more interaction with patients than they did in the past. Another change mentioned was that in some practices, nursing staff were now talking with patients about self-management techniques and approaches for managing chronic conditions. One person made a distinction between patient education and patient self-management and said,

"patient education is just trying to get through all the medical jargon, to make sure people understand the test you're doing and why you're doing it and what your disease is, and what it is and how bad it's going to be for them or good or what they can do. And then patient self-management is trying to establish with the patient something for them to do and tools for them to do to manage their disease."

Self-Management Approach
The addition of self-management approaches to the APCP-PCMH model of care created some concern for Blueprint-related team members. Primarily discussed was the uncertainty about sustained funding in support of CHT member roles and responsibilities. To instill self-management approaches within practices, rather than rely on members of a CHT to meet this need, NMC staff already trained in motivational interviewing techniques shared this knowledge and expertise with nursing staff from local provider offices. One provider spoke about limited access to DASH diet materials as detrimental to provider support of patient's self-management activities.

Expectations for the Future
Future expectations included hopes that additional practices would join the Blueprint model of care and become APCP recognized. Many reported that Blueprint supported other healthcare transformation efforts and incentives such as meaningful use and payment reform. Providers anticipated continued alignment between practices and the hospital. Some hoped for clearer direction from the state as to where and what was expected in terms of future changes in the healthcare delivery system. Others discussed the anticipation of having Blueprint provide additional resources and staff to help support and coordinate care. A person spoke of continued collaboration as a priority and on-going expectation of the Blueprint stating, "*I think we are at a point where we can no longer operate in silos.*"

Role of the Project Manager, Practice Facilitator & Practice Coach
Many talked of the important role provided by the project manager, practice facilitator and practice coach. The project manager role was often described as a "balancing act" in which intentions of both the state and local providers need to be served. A reported benefit to Blueprint's adoption in the St. Albans HSA is the positive working relationship between the project manager and practice facilitator. Weekly meetings assure good communication between these roles and supports continued progress with implementation activities. Practice facilitator support with the self-management piece of APCP recognition was reported as especially beneficial to local providers. In addition, the practice facilitator's access to a statewide network of colleagues working simultaneously to assist local practices with APCP implementation has resulted in improved access to self-management support tools. One example included the

practice facilitator's access to colleagues in other parts of the state that were willing to solve a need for software to support self-management approaches in St. Albans. The participant said, "*I think [access to a statewide network of colleagues doing this work] has been really powerful. We feel kind of isolated up here in the northwestern corner of the state, but guess what? I have access to a practice in Bennington and I don't even know those people. And they are helping us.*"

CHT Implementation
As mentioned previously, concerns about the sustainability of the CHT was discussed by several interview participants. Also frequently mentioned is uncertainty about how best to staff the CHT. One person spoke of the challenge ahead, "*the whole idea of this community health team is great in theory, but how do you implement it? How do you actually put it in place?*" The clinical workgroup is currently working to define roles and responsibilities of the CHT. Several reported that development of the CHT takes time as building consensus among workgroup members is a time consuming process. Many spoke of the need to gain sufficient buy-in among all concerned as key to the CHT's future success. The group has recently been working to develop a CHT model which augments, but does not duplicate existing services. Once built, several mentioned a concern that the team could be inundated with requests. Several providers indicated a desire for the CHT to provide self-management and behavioral health supports, nutrition, as well as connections to community supports.

Recommendations
Suggestions for improved healthcare delivery that were voiced among those interviewed include:
- Improved communication among Blueprint state-level staff and community members (i.e. objectives/agendas shared with participants in advance of meeting, timely start to conference calls).
- Improved definition of Project Manager and Practice Facilitator roles within the Blueprint model of care.
- Consider advocating for healthcare reforms within other service sectors, such as durable medical equipment, prescription drugs, and in-patient care.
- Complete financial analysis of actual costs involved with providing care within an APCP setting.
- Realign the healthcare compensation system to better support primary care. Reduce costs by streamlining billing requirements.
- Better support patient access to affordable and adequate insurance coverage, which includes access to prescription medications and does not necessitate rationing of one's care.
- Reduce prior authorization requirements, which are time consuming and inefficient.
- Assign a greater value to the role of primary care practice within the healthcare continuum to reduce attrition among providers.
- Include practitioners and those directly impacted by the healthcare transformation efforts in the actual work of Blueprint. As one person said, "*I think you have to have doctors who know the pressures of what asking one more thing is going to do.*"
- Provide recognition for the amount of time and work involved with gaining recognition and operating as an APCP-PCMH. Consider providing practice staff with access to similarly structured providers for technical assistance support (e.g. small practice support offered to similar sized practices).

Individual Interviews with Patients / Blueprint Medical Home Consumers of Healthcare

Mt. Ascutney & St. Albans
Interviews were conducted with 20 patients of primary care providers (PCPs) and parents of 2 patients of a pediatric practice. Reported patient-provider relationship lengths ranged from several months to 23 years. Most participants had long-standing relationships with their physicians, many of whom had been a patient of the same provider for more than fifteen years. One patient had changed providers in the past year due to concern about the treatment received for his/her condition. Sixteen patients of recognized APCPs were interviewed; 6 patients received care from not yet NCQA recognized PCPs.

Reported chronic health conditions varied, with a majority of the 20 patients experiencing diabetes, high blood pressure, high cholesterol, and cardiac issues. For these patients, a myriad of other conditions was often present. Fewer reported anxiety and/or depression, and arthritis. The two other patients received well-child care from their pediatrician. A majority of participants see the same provider at each visit, which is a reported change in one of the most recently recognized APCPs. Interactions are said to occur in person, unless interim phone calls are made to the provider. In those instances, patients are generally routed to the practice nurse. At the time of visit, follow-up or other routinely scheduled appointments are made, often at intervals of once every three to four months. Lab work in advance of office visits are pre-scheduled so that results are available at appointment. Nearly all participants reported they enjoyed good access to their provider. Appointments outside those already routinely scheduled were generally available either the same day or within one to two days of contacting the office.

Addition of the EMR was most frequently discussed as the primary change in practice operations. Some described the "thoroughness" of the visit now that doctors appeared to ask questions based upon information contained within the EMR. Patient summaries, where and when offered, helped encourage patients to track their progress and be better informed about their health. As one person indicated, "*[the visit summary] gives me a better sense of wellbeing, that I know what's going on and I know which way I'm tracking.*" Medication lists generated by the EMR were also reported to be a beneficial tool in managing one's condition. One person said, "*the medication list is a good reminder. I take 25 prescriptions a day, you might lose track of why you're taking a particular one, but [the printed medication list] helps to refresh in my mind why I'm taking those things for.*"

Access to specialty care was favorable and said to be nearly always arranged by the provider. Good coordination between PCPs and specialists was reported to occur. In one instance, lab reporting between a Vermont provider and New Hampshire based hospital was problematic in that results were not available at the time of appointment. Access to psychiatric services was limited; while orthopedic surgeon services were said to be readily available. One patient spoke of frustration that a specialty cardiac provider did not seem to be listening to his/her concern and unable to provide a probable explanation for continued chest pain.

Themes that most frequently developed from interviews with patients include: relationship with provider, observable changes in practice, indicators of self-management, barriers to self-management, and recommendations for improvement in the delivery of healthcare. Mt. Ascutney patients described positive interactions with members of the CHT that has been operating there since January 2010. In St. Albans, several spoke of the benefit received from participation in Healthier Living Workshops and/or diabetes education classes.

Relationship with Providers

Nearly all of the patients interviewed reported they enjoyed favorable relationships with their providers. Questions were easily asked and a patient/doctor dialogue seemed to consistently take place during office visits. Most felt they were well-informed about their conditions and treatment plans. One participant said, "*I've never changed doctors in all these years – it's home to me, whatever I need, I can get here.*" Another indicated the personal connection between patient and provider when talking about his/her doctor's recent recommendations about diet,

> "*I've been able to shake a few pounds recently and so I got commended on that. But there's also to me, a compassionate understanding that we know why you are what you are, and do the best you can…..It's paramount to me to have a medical provider that really cares about you and your condition. You're not just a number.*"

Still another discussed the fact that he/she didn't feel rushed during provider visits and that all questions were answered, no matter how long they took to resolve. Several talked of the primary care physicians' role in coordinating care. One person indicated this by saying, "*it's my doctor putting me in to see these other doctors, specialists, for me to obtain care from……he's the primary care and that's pretty much what his job all boils down to as far as I know.*"

Observable Changes in Practice

Several changes in practice operations were described. One participant noticed an increase in the frequency of visits, from two to now at least four times per year. This same person also noted a change in his/her access to foot care. The patient's APCP had referred him/her for regular podiatry care to assist with nail trimming, etc. Another discussed reduced appointment wait times. Others reported improved access to specialty care resulting from APCP referrals and appointment scheduling.

A person adeptly summarized observable differences following the addition of the CHT model of care, "*They used to have other diabetic coordinators and stuff and there was never much coordinating going on.*" This participant reported changes in his/her behavior that included first time planting of a garden so vegetables would be more readily available and affordable. Another participant who had recently changed providers from New Hampshire to Mt. Ascutney described the difference in care when saying, "*they are trying to view the whole picture.*" Several participants interviewed who were receiving care in a pediatric setting discussed changes in developmental screening practices. One person said,

> "*I like that my doctor is linking development with health because some aren't making that before they check in and they say, so it looks like this is happening, so I think they're able to get a bigger picture instead of oh, I forgot to ask the question. It's more prevention focused.*"

Indicators of Self-Management

Many of those patients interviewed described interactions with providers related to self-management activities and approaches. For instance, a patient described goal setting during a recent office visit whereby the provider had discussed exercise and completion of a daily food log to assist with management of his/her diabetes. Interviews consistently revealed that self-management discussions between patients and providers were taking place. As discussed below, many indicated they knew what they needed to be doing in terms of self-management activities, which included proper medication management, eating a healthy diet, getting exercise and obtaining the necessary follow-up care.

Barriers to Self-Management

While a majority of patients discussed awareness of what needed to be done to manage their chronic conditions, barriers to actually implementing recommendations sometimes precluded

one's ability to follow-through. As one person stated, "*It's not a lack of quality care here. It's a lack of me following [through with provider recommendations].*" Most indicated they were compliant with medication management. However, challenges with following recommended diet and exercise routines were frequently described. For instance, a reported barrier to management of diabetic conditions often related to the affordability of foods recommended for people with this chronic health issue. "*For the most part I do [know what to do to manage my health], but when it comes down to the stuff I should be doing, I can't afford. It all comes out to whether I can afford to do it the way it's got to be done. And most of the time, I can't afford it.*" Some described motivational barriers and the inability to change habitual behaviors. As one said, "*it's really hard to change habits after you've been eating a certain way for such a long time.*" Several others discussed challenges to exercise because of past conditions which limited his/her ability to engage in these activities. One talked about the winter weather as a deterrent to walking for many months of the year; a treadmill was found to be too boring. Many indicated that pain and/or limited oxygen levels precluded attempts to walk, sometimes even short distances. Limited access to transportation for a patient with depression meant that he/she could not get out as often as desired, which only perpetuated feelings of isolation and solitude. Another patient spoke of getting sidetracked and preoccupied with other priorities, which resulted in less favorable lab results. An inability to consistently follow-through with provider recommendations seemed to be a primary barrier to self-management activities.

Patient Recommendations for Improvement in Delivery of Healthcare
A few participants offered suggestions for improvements in the delivery of healthcare. The following ideas were shared:
- Suggestion that patients, in certain situations, would prefer to talk directly with the doctor rather than having their calls routed through the nurses.
- Preference to be followed by one doctor, rather than several, during necessary hospital stays.
- Providing access to male social workers for a male population of patients who might feel more comfortable talking with a man rather than a woman.
- Availability of x-ray equipment in remote practice locations.
- Provide interoperability between healthcare provider information and data reporting systems.

Mt. Ascutney – Access to CHT Members
The CHT has been operating in Mt. Ascutney since January 2010. Many of those interviewed in this HSA indicated positive benefits from having accessed services provided by CHT members. One participant described the benefit of contact by the Care Coordinator, "*she drops me a line and when she doesn't hear from me after a certain amount of time, she'll call me to find out how I'm doing. She's always checking up on me. She's like the mother that I lost, you know.*" Reported improvements from CHT interaction include access to diabetic testing equipment and supplies that encourage and support better self-management. One person stated, "*She helps me to be able to test more often.*" Others described assistance with oxygen deliveries and the Care Coordinator's on-going contact with the patient's caregiver as beneficial.

Access to and support with public assistance forms and insurance was another reported beneficial practice provided by CHT members. One person said, "*I don't read very well. That's one of my biggest problems. I can absorb the stuff by talking but as far reading a lot of this stuff, it don't make heads or tails to me, like trying to get help with the Welfare Department.*" Another participant indicated the comfort in knowing who to call with any type of issue, and for assistance with prescription refills and access to transportation.

St. Albans – Access to Healthier Living Workshops and Diabetes Education
Positive benefits were indicated for those patients in St. Albans who had attended hospital-sponsored diabetes education and/or Healthier Living Workshops. One person said, "*the health class was the best class I had gone to…..[what was most beneficial was] the feeling of support and that I wasn't the only one having problems….it was nice because it made us all feel all interconnected.*" This participant further explained how the class had provided motivation to set obtainable goals and move beyond barriers caused by his/her depression. Several participants spoke of discontinued soda consumption after having attended the diabetes education classes. Many also reported improvements to their diet as a result of the educational information provided by one-on-one counseling sessions and class attendance.

KEY FINDINGS AND SUMMARY

Key Findings
Several key findings from interviews with practice provider and staff, and Blueprint-related team members include:
- The work required to achieve APCP recognition is time consuming and labor intensive, and best facilitated in practices which have an operating EMR.
- Blueprint's transformation efforts align well with other initiatives such as meaningful use and healthcare payment reform.
- The practice facilitator role supports practices with implementation of self-management approaches and techniques, as well as preparation for NCQA recognition.
- CHT development and integration within practice settings can be challenging.
- Payment and incentive models continually need to be evaluated and updated to assure quality and holistic supports are available to patients.

Several key findings from interviews with patient / Blueprint medical home consumers of healthcare include:
- Consumers of healthcare services primarily attribute changes in practice to EMR usage.
- Patient perspectives reflect transformation within primary care practices are progressing as evidenced by: improved access to providers, specialty care and community supports (e.g. access to insurance, availability of diabetic management supplies and testing equipment), opportunities for education in self-management and care of chronic conditions, and access to coordinated care.
- Despite awareness of self-management techniques, changes in habitual behaviors and control of one's desires are not necessarily easy to achieve.

Summary
A primary goal of the practice provider and staff, and Blueprint-related team member interviews was to identify experiences and reflections related to adoption of the Blueprint model, satisfaction with current activities and expectations for the future. As the Blueprint moves towards statewide adoption in 2011, an analysis of developments within an APCP setting are important in further understanding the Blueprints' strengths, accomplishments, and challenges. In addition, individual interviews with patients were conducted with the goal of gathering information about their perceptions of changes in the delivery of health care services.

This report achieves the above goals and demonstrates Blueprint's progress and on-going evolution in Vermont. Indicators of success, challenges and opportunities related to Blueprint

adoption within the Mt. Ascutney and St. Albans communities is hoped to assist other providers in the state as they move towards APCP-PCMH recognition. Continued monitoring of patient experiences within the primary care practice setting and plans to systematically measure, on a larger scale, patient perceptions is advisable. In addition, on-going monitoring of APCP improvements and changes will inform future advances in healthcare reform efforts.

Appendix A.: Healthcare Providers Recruitment Strategy and Discussion Guide

<u>Recruitment Strategy: Healthcare Providers</u>

VCHIP will contact Blueprint project managers in St. Albans and Windsor to confirm which Community Health Team (or people in roles similar to a CHT), practice staff and providers should be included in 45 minute in-person interviews. Project Managers will also be interviewed if they are interested in participating. Both practice locations are currently participating in VCHIP's evaluation of the provider practice component of the Vermont Blueprint for Health. Individuals identified will be asked to either invite staff and providers to participate in a discussion with researchers about their interest in being interviewed about their impressions of their practice systems or to share practice staff and provider names and work email addresses with VCHIP so VCHIP staff can send the invitation. The content of the message will include a brief overview of the interview's goal (i.e., to get their impressions of the Blueprint and their practice systems), the date, time, and location of the interview, contact information for VCHIP so they are able to ask questions and r.s.v.p., and let them know that they'll receive an honorarium.

Individuals assisting with recruitment (Blueprint project managers) will also be asked to help set meeting dates, times, and locations.

Primary care practice staff and providers will be consented by interviewer/members of the research team before the interview begins. If interviews are conducted over the phone, consent will be obtained prior to the phone call. As described in the consent form, subjects will be given an honorarium for attending the discussion. As is required by the University of Vermont for tax reporting purposes, subjects will have to share their name, home address, and social security number in order to receive the honorarium. Consistent with procedures for storage of the interview data, this information will be kept secure in locked files and/or secure networks.

<u>Discussion Guide Outline: Blueprint Practice and Provider Interviews</u>

<u>Introduction</u>
- Welcome
    - o Thank participant for agreeing to be interviewed
    - o Interviewer / participant introductions
- General description of the Blueprint
    - o State-led healthcare project working to improve health and healthcare of Vermonters
- Goal of the interview
    - o Learn more about the Blueprint's strengths and the challenges it faces from people who work at or with primary care practices participating in the Blueprint
        - ▪ Experiences relating to the adoption of the Blueprint model
        - ▪ Reflections on experiences with the Blueprint
        - ▪ Satisfaction with current Blueprint activities
        - ▪ Expectations for the future
    - o To learn how the transition to a patient-centered medical home has influenced work and perceptions of healthcare
- Description of interview protocol
    - o Interview will consist of a series of questions and will last approximately 45 minutes
    - o Interview will be recorded

- o names will be identified in summary report but it may be possible for readers familiar with the Blueprint and the local community to identify the source

<u>Interview Topics:</u>
Interview participants will be asked to articulate their community and practices' strengths, challenges, and needs in the following areas:
- Practice systems and workflow (policies, processes, and documentation, IT, staffing)
- Relationships and interactions (between practice staff, the practice and community care team, the practice and patients, the practice and the community)
- Description of how the Blueprint model was introduced, developed and implemented in their community

Appendix B.: Blueprint Medical Home Consumer of Healthcare Recruitment Strategy,
Discussion Guide and Interview Questions

Recruitment Strategy: Blueprint Medical Home Consumer of Healthcare Interviews
VCHIP will ask primary care providers and practice staff participating in interviews about their
experiences with the Blueprint (Blueprint Healthcare Provider Recruitment Strategy and
Discussion Guide) to come up with a list of patients that might be able to provide further insight
into healthcare delivery in their community. We will ask them try to think about patients who
have visits scheduled on one of several days. As a result, interested patients will not have to
make a special trip for the interview.
They will also be asked to limit their list to:
- Patients who are 18 years old or older AND
- have some sort of chronic condition,
- require some form of care management,
- or have used Community Health Team or Community Health Team-like services.
When conducting reminder calls to patients prior to their scheduled office appointment, the
practice will ask patients on the list they have generated if they might be interested in being
interviewed about their healthcare experiences. Prospective participants will be told that if they
are interested, an interviewer will be able to meet with them before or after their medical
appointment to discuss the details of the interview and conduct the interview if the patient is
interested. They will also be told that they'll receive $25 if they choose to participate.
When patients interested in learning more about the interview arrive at the practice or have
completed their appointment they will be shown to a room where the interviewer is waiting. She
will provide an overview of the project and consent interested patients. She will then conduct
the 45 minute interview. If, after providing an overview, the patient decides he/she doesn't want
to participate, he/she will be thanked for his/her time and the interview will not be conducted.
VCHIP conducted similar interviews last year. Four were with people seen by several of these
same practices. Practice staff will also be asked to ask these patients if they are interested in
talking over the phone with the same interviewer. Phone numbers of interested patients will be
given to the interviewer and she'll call them to conduct the interview.

Discussion Guide Outline: Blueprint Medical Home Consumer of Healthcare Interviews
The interviewer will describe that the discussion's goal is to understand more about the
consumer of healthcare's healthcare experiences and his or her impressions of their primary
care practice's strengths, challenges, and needs. He or she will be told that the discussion will
be recorded. The interviewer and the consumer of healthcare will then go over the consent form
and sign it, if he or she wants to participate. As described in the consent form, participants will
be given an honorarium for attending the discussion. As is required by the University of
Vermont for tax reporting purposes, participants will have to share their name, home address,
and social security number in order to receive the honorarium. As with interview data, this
information will be kept secure in locked files and/or secure networks.

Discussion Topics: (Actual questions may vary based on participants' health and healthcare
experiences)
Access to Healthcare: We want to learn more about your experiences accessing the healthcare
you need.
Gather name of the provider and chronic health condition(s)
1. How long have you been a patient of Dr. X?
2. How often do you see your doctor/primary care provider?
3. Do you generally see your doctor/primary care provider or someone else?

4. Do you find that you can easily access your doctor/primary care provider?
5. Please describe a typical interaction with your doctor/primary care provider (probe for who initiates the discussion, ability to ask questions, is she/he given handouts or materials, appointments scheduled in advance, etc.).
6. Do interactions with your doctor/primary care provider generally occur in person or does anyone from the practice ever call you or e-mail you about your health? (describe changes in interaction/communication patterns between consumer and practice)
7. What other health care providers do you see and how often (e.g., other doctors, health educators, behavioral health specialists/counselors, nurses, care coordinators)?
    a. Please describe your level of satisfaction with access to these providers.
    b. Also describe how they help manage your chronic health condition.
8. What other healthcare <u>services</u> do you access (e.g. specialty care, home health, emergency room, community mental health center)?
    a. Please describe your level of satisfaction with access to these services.
    b. Also describe how they help manage your chronic health condition.
9. Can you think of any changes or improvements your doctor/primary care provider, other health care provider or service could make to improve your access to care?

<u>Coordination of Care</u>: One of the Blueprint's goals is that a patient's primary care practice makes sure that he or she is getting all the services that he or she needs. Ideally, the practice should help the patient to coordinate services.
10. Please describe any experiences you have with coordination of your healthcare services. (Has your primary care practice helped set-up appointments at other doctors' offices, the hospital, any kind of social or community service?)
11. Do you have any suggestions for your practice regarding the coordination of your care?

<u>Self-Management</u>: Vermont is also working to make sure that people have the knowledge and the tools they need to keep healthy or to work on improving their health.
12. Do you think you know what you're supposed to be doing to manage your health? (When you leave the doctor's office, do you know what medications you should be taking, what kinds of food you should be eating, what kind of exercise is appropriate, and what kind of services you should be pursuing?)
13. Do you feel you can do what you need to do to manage your health? (How capable are you at taking your medications as prescribed, following a specific diet, getting the right exercise, and following through on referrals?)
14. What, if any, barriers get in your way of successfully managing your health?
15. What additional supports, if any, do you think you need to manage your health?

<u>Perception of Overall Health</u>: We would like to get an overall sense of how the Blueprint is impacting the health care delivery system and the care you receive.
16. How would you describe your overall experience with the healthcare you receive – do you have access to the care you need, when you need it, do you feel like your care is coordinated and that you have the tools to manage your chronic health condition?
17. Can you think of anything else you think would be helpful for the Blueprint and your practice to know about your experience as a patient in this community and at *insert practice name*?

<u>Conclusion</u>: That covers the questions that I have to ask. Thank you so much for sharing your experiences with me today. Provide information about how to contact VCHIP with additional comments, questions, or concerns