**Vermont Blueprint For Health
Implementation Manual**

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Agency of Human Services

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1   Introduction to Blueprint for Health Manual

1.1   Intent

The Blueprint is a state led program dedicated to achieving well coordinated and seamless health services, with an emphasis on prevention and wellness, for all Vermonters. Acting as an agent of change, the Blueprint is working with a broad range of stakeholders to implement a novel health services model that is designed to; Improve the health of the population; Enhance the patient experience of care (including quality, access, and reliability); and to Reduce, or at least control, the per capita cost of care. A growing national consensus suggests that this Triple Aim, as promoted by the Institute for Healthcare Improvement (IHI), can be achieved through health services that are safe, effective, efficient, patient centered, timely, and equitable (*Crossing the Quality Chasm: A New Health System for the 21st Century.* Washington DC: National Academy Press, Institute of Medicine; 2001).

The foundation of the Blueprint model is Advanced Primary Care that meets patients and families needs by coordinating seamlessly with a broad range of health and human services. This Manual is a guide for primary care practices, health centers, hospitals, and providers of health services (medical and non-medical), to implement the Blueprint's Multi-payer Advanced Primary Care Practice (MAPCP) model in their community, and to become part of a statewide Learning Health System. The Blueprint model includes the following components: multi-insurer payment reforms that support advanced primary care practices and community health teams; a statewide health information architecture that will support coordination across a wide range of providers of health and human services; and an evaluation and quality improvement infrastructure to support a Learning Health System which continuously refines and improves itself.

1.2   Process for Updating Blueprint for Health Manual

Consensus-building has been and remains essential to the planning, implementation and evaluation of the Blueprint. To this end, the committees described in Section 2 advise the Blueprint Director. The Blueprint Director will approve changes to the Blueprint for Health Manual that potentially modify the requirements of the insurers, hospitals, primary care practices or others, based on guidance and, when possible, consensus of the advisory groups and key stakeholders.

A stakeholder can appeal the decisions of the Blueprint Director to the Commissioner of the Department of Vermont Health Access (DVHA), who shall provide a hearing in accord with Chapter 25 Title 3.

2 Advisory Groups

2.1 Blueprint Executive Committee

Purpose: The Blueprint Executive Committee shall provide high-level multi-stakeholder guidance on complex issues. The Blueprint Executive Committee shall advise the Blueprint Director on strategic planning and implementation of a statewide system of well coordinated health services with an emphasis on prevention. The Blueprint Executive Committee Members represent a broad range of stakeholders including professionals who provide health services, insurers, professional organizations, community and nonprofit groups, consumers, businesses, and state and local government.

Committee Make-up: The Blueprint Executive Committee shall consist of no fewer than 10 individuals including but not limited to:

- Commissioner of Health
- Commissioner of Mental Health
- Representative from the Department of Banking, Insurance, Securities, and Health Care Administration
- Representative from the Department of Vermont Health Access
- Representative from the Vermont Medical Society
- Representative from the Vermont Nurse Practitioners Association
- Representative from a Statewide Quality Assurance Organization
- Representative from the Vermont Association of Hospitals and Health Systems
- Two Representatives of Private Health Insurers
- Representative of the Vermont Assembly of Home Health Agencies who has clinical experience
- Representative from a Self-insured Employer who offers a Health Benefit Plan to its Employees
- Representative of the state employee's health plan, who shall be designated by the director of human resources and who may be an employee of the third-party administrator contracting to provide services to the state employees' health plan
- Representative of the complementary and alternative medicine professions
- A primary care professional serving low income or uninsured Vermonters
- A consumer

In addition, the Director of the Commission on Health Care Reform shall be a nonvoting member of the Executive Committee.

Meeting Frequency: Regular meetings shall be held monthly, convening no fewer than 6 times annually. Meeting schedules, committee membership, minutes and updates can be found by going to http://dvha.vermont.gov/advisory-boards

Members Responsibilities: Members shall be expected to attend all meetings except as they are prevented by a valid reason.

2.2   Blueprint Expansion Design and Evaluation Committee

Purpose: The Blueprint Expansion Design and Evaluation Committee shall advise the Blueprint Director in more detailed planning related to program design, including modifications over time, for statewide implementation of the Blueprint model and to recommend appropriate methods to evaluate the Blueprint.

Committee Make-up: The Blueprint Expansion Design and Evaluation Committee is composed of but not limited to the following individuals:
• Members of the Executive Committee (or designee)
• Representatives of participating health insurers
• Representatives of participating medical homes and community health teams
• Deputy Director of Health Care Reform
• Representative of the Bi-State Primary Care Association
• Representative of the University of Vermont College of Medicine's Office of Primary Care
• Representative of Vermont Information Technology Leaders, Inc.
• Consumer representatives

Meeting Frequency: Regular meetings will be held every other month with no fewer than six meetings annually. Meeting schedules, committee membership, minutes and updates can be found by going to http://dvha.vermont.gov/advisory-boards.

Members Responsibilities: Members shall be expected to attend all meetings except as they are prevented by a valid reason.

2.3   Blueprint Payment Implementation Work Group

Purpose: The purpose of the Blueprint Payment Implementation Work Group is to implement the payment reforms that support advanced primary care practices and community health teams, design the payment mechanisms and patient attribution strategies, modifications over time, and to make recommendations to the Blueprint Expansion Design and Evaluation Committee.

Work Group Make-Up: The Blueprint Payer Implementation Work Group is composed of but not limited to the following individuals:
• Representatives of the participating health insurers (public and commercial)
• Representatives of participating advanced primary care practices and community health teams
• Administrative and project management leadership in each Hospital Service Area
• Commissioner of the Department of Vermont Health Access or designee

Meeting Frequency: The Blueprint Payer Implementation Work Group shall meet no fewer than six times annually. The work group complies with open meeting and public record requirements. Meeting schedules, work group membership, minutes and updates can be found by going to http://dvha.vermont.gov/advisory-boards.

Members Responsibilities: Members shall be expected to attend all meetings except as they are prevented by a valid reason.

2.4 Blueprint Provider Practice Advisory Group

Purpose: This 15-member group serves as a clinical "sounding board", advising the Blueprint Director and Associate Directors, researching and recommending evidence based clinical guidelines for health maintenance and chronic diseases. It also serves as an informal forum for providers to share their experiences as participants in the Blueprint.

Advisory Group Make-Up: The Blueprint Provider Practice Advisory Group is composed of but not limited to the following members.
- Primary care providers in independent practice settings
- Primary care providers in affiliated practice settings (hospital and/or parent-organization-owned)
- Primary care providers from academic settings
- Representative of the Vermont Medical Society

Meeting Frequency: The Blueprint Provider Practice Advisory Group meets on a quarterly basis. Meeting schedules, advisory group membership, minutes and updates can be found by going to http://dvha.vermont.gov/advisory-boards.

Members Responsibilities: Members shall be expected to attend all meetings except as they are prevented by a valid reason.

3 Hospital Service Area Organization

3.1 Administrative Entity

Key stakeholders in each hospital service area (HSA) must agree upon and identify at least one administrative entity accountable for leading implementation and ongoing operations of the Multi-payer Advanced Primary Care Practice (MAPCP) model in their HSA, and meeting requirements of the Blueprint program. Lead administrative entities within each HSA will also receive multi-insurer payments to support hiring of Community Health Teams, and therefore must be Centers for Medicare and Medicaid Services (CMS) eligible providers. As with the Blueprint program overall, a consensus-oriented process is used to identify administrative entities within each HSA. To accomplish this, Blueprint team leaders meet with key stakeholders in each HSA to present the overall design, strategies, goals, the requirements of the program, and to establish an HSA planning committee. The HSA planning committee within HSAs must include providers from a wide range of settings that reflect the primary care makeup in the HSA community including (but not limited to) hospital and/or parent organization-affiliated practices, independent practices, and health centers. Additional stakeholders that are expected to be part of the planning committee include but are not limited to hospital leadership (administrators and information

technology leaders), a range of medical and non-medical providers of health and human services in the HSA (e.g. social services, economic services, care support services), and leadership from the local District Office of Public Health. Through a consensus process, this work group will identify the lead administrative entity. To date, given the resources and infrastructure that are required to act as a lead administrative entity, and the requirement that the lead administrative entity be a CMS eligible provider, hospitals and health centers have emerged as such (although the choice is not limited to these examples). When consensus cannot be reached, and/or there is a need for more than one administrative entity, the Blueprint team will work with the key stakeholders in each HSA to craft a workable solution.

The lead administrative entity will support the work of the overall HSA Planning Committee including the work of two committee subgroups, an Integrated Health Services (IHS) workgroup and a Health Information Technology (HIT) workgroup. **The IHS workgroup** provides the forum for planning community health team composition, strategies for coordinated health services, and logistics for scoring participating primary care practices based on NCQA Physician Practice Connections - Patient Centered Medical Home (PPC-PCMH) standards. **The HIT workgroup** provides the forum for leaders from each practice and organization to work with Vermont Information Technology Leaders, Inc. (VITL) and the entity operating and maintaining the Blueprint centralized registry (DocSite), to plan and implement participation as part of Vermont's health information infrastructure. This includes planning how each organization and practice can optimize use of core guideline based data elements, transmit data to the central registry, and develop interfaces for connection to the HIE network.

The formation and application process for becoming a new MAPCP model community is directly encouraged through a formal outreach process conducted by the Blueprint staff and may also be initiated directly by an interested community and lead organization(s).

In either case, two signed copies of the MAPCP model community application must be submitted to:

> Attn: Blueprint Associate Director
> Department of Vermont Health Access
> Vermont Blueprint for Health
> 312 Hurricane Lane, Suite 201
> Williston, VT 05495

The application for designation as a MAPCP model community is available at http://hcr.vermont.gov.

The Associate Director will acknowledge receipt of the preliminary MAPCP model community application by email and will add the community and lead administrative entity(s) to its statewide database of prospective and active MAPCP model communities.

Consistent with the standard State of Vermont grant and contracting process, the administrative entity must demonstrate sufficient fiscal capacity and experience with fiduciary responsibility to serve as the recipient of Blueprint funding and that from the participating insurers for support of the Community Health Teams. The administrative entity must take full, legal responsibility for all payroll and benefit functions, and transactions conducted on behalf of the community to implement the Blueprint initiative. Evidence of this capacity is demonstrated is in the language of each Hospital Service Area grant.

The administrative entity must agree to fully participate in the Blueprint Evaluation. Examples of evaluation activities include populating the Blueprint Centralized Registry with core data elements, working with the Blueprints practice facilitators on ongoing quality improvement as part of a learning health system, facilitating NCQA Patient Centered Medical Home scoring and direct chart review processes in participating primary care practices, and facilitating qualitative data collection processes such as focus groups and interviews. Evidence of this agreement is demonstrated in the language of each Hospital Service Area grant.

The administrative entity must demonstrate local Health Information Technology capacity, including the hospital and primary care practices working with the company that maintains and operates the Blueprint Centralized Registry (DocSite) and with Vermont Information Technology Leaders, Inc. (VITL).   See section 4.5 for more detail.

The Division of Health Care Reform maintains a comprehensive project management-planning tracking tool to demonstrate the statewide expansion of the Blueprint in tandem with that of other Health Care Reform initiatives, such as adoption of Electronic Health Records (EHR) and interoperable connectivity to the Vermont Health Information Exchange (VHIE). The administrative entity is required to maintain a Blueprint implementation and ongoing improvement plan inclusive of the components of the Blueprint for Health Manual and listed in Appendix A, update the Blueprint database with current information about the local status of Advanced Primary Care Practices (APCPs), Integrated Health Services (IHS), and Health Information Technology (HIT). The administrative entity must submit bi-annual progress reports to the Blueprint Associate Director by April 30 for the period of October 1 to March 31; and November 1 for the period of April 1 to September 30. A list of required data elements demonstrating progress is included in Appendix B of this document.

3.2   Project Management

The administrative entity in each HSA must retain an overall project manager, a clinical leader and a health information technology leader. It is the joint responsibility of these 3 leaders to ensure that the planning and implementation strategies of the Integrated Health Services (IHS) workgroup and the Health Information Technology (HIT) workgroup are synchronized. While IHS and HIT planning and implementation happen in parallel, there needs to be a level of coordination that occurs between the groups. This coordination ensures that certain time sensitive elements of each group are completed at close to or at

the same time. For example, before payment reforms supporting Advanced Primary Care can commence, the Advanced Primary Care Practices (APCPs) must have achieved NCQA PPC-PCMH scoring at or above Level 1 by the University of Vermont Child Health Improvement Program (VCHIP), completed an approved Community Health Team plan, and have in place signed VITL and Blueprint Registry business associate agreements. It is also necessary to demonstrate that technical work is underway to optimize use of the Blueprint's guideline based core data elements, to implement data transmission from practice setting to the centralized registry, and, where necessary, to develop interfaces to support data transmission from the primary care setting that will support Vermont's HIT plan and the VITL HIE network. Aligning implementation of all these components of the Blueprint MAPCP model will establish a foundation for seamless well-coordinated health services.

Project Manager: The project manager is responsible for overseeing the implementation of the Blueprint model of Advanced Primary Care within the local HSA. To that end, the project manager will:
- Facilitate (or assign an appropriate designee to facilitate) the local planning groups, ensure a broad stakeholder representation on the groups, and make sure they are coordinated in terms of scheduling, tasks and membership.
- Document and maintain an implementation plan and timeline including the development and expansion of the CHT; connectivity with the HIE and utilization of the Blueprint Registry; and progress of all primary care practices (hospital and/or parent organization-owned and independent) on the path to becoming APCPs.
- Ensure that all primary care practices are informed of the local Blueprint initiative and document their participation and progress toward becoming an APCP.
- Participate (or designate an appropriate representative from the HSA to participate) in the meetings of the Blueprint Expansion Design and Evaluation Committee and Payment Implementation Work Group.

Clinical Leader: A local clinical champion (a provider of primary care) must be designated and must participate in the Provider Advisory Group, the local IHS workgroup planning meetings, as well as guide his or her colleagues through the application and implementation process. Examples include working with the Provider Practice Advisory group to identify nationally accepted evidenced-based guidelines, facilitating discussions with local clinicians regarding implementing the nationally accepted evidence-based clinical guidelines embedded in the Blueprint Registry and used in the Blueprint evaluation, speaking with local practices to garner their participation in the Blueprint initiative, and facilitating local communication between practices and Blueprint Practice Facilitators as part of a statewide Learning Health System.

Health Information Technology (HIT) Leader: A Health Information Technology (HIT) leader must be identified to ensure the accomplishment of objectives in Section 3.1 of this document. The role of the HIT leader is to facilitate planning and implementation of the Blueprint health information architecture in the HSA, including linkage with the HIE network. This involves coordination with the HSA Project Manager, Clinical leaders,

clinical and technical support for the central registry (DocSite), and VITL project management.

3.3   Local Work Groups

The Project Manager must convene and maintain 2 local workgroups, one each for **Integrated Health Services (IHS)** and for **Health Information Technology (HIT)** planning and implementation. In addition, it is recommended that each primary care practice site develop an internal **Advanced Primary Care Practice** quality improvement team.

The **IHS workgroup** is intended to guide the process of implementing Advanced Primary Care and coordinated health services in the HSA. The IHS workgroup provides the forum for planning community health team composition, strategies for coordinated health services, and logistics for scoring participating primary care practices based on NCQA Patient Centered Medical Home standards.

Membership of the **IHS workgroup** should include, but is not limited to:
- Clinicians and staff from primary care practices
- Hospital administrators
- Clinical and IT leadership
- Medical and non-medical providers from community service organizations
- Mental health and substance abuse counselors
- Department of Health district offices leaders
- Childrens' Integrated Services Intake Coordinators
- School nurses
- Consumers/Patients

Efforts must be made to include all adult and pediatric primary care practices (independent as well as hospital and/or parent organization-owned) that demonstrate interest in being part of the MAPCP model.

The **HIT workgroup** provides the forum for leaders from each practice and organization to work with the Vermont Information Technology Leaders (VITL) and the entity operating and maintaining the Blueprint centralized registry (DocSite), to plan and implement participation as part of Vermont's health information infrastructure. This includes planning how each organization and practice can optimize use of core guideline based data elements, transmit data to the central registry, and develop interfaces for connection to the HIE network.

The **HIT workgroup** may have a more limited membership appropriate to its focus. It must, however, have as a minimum the following representatives:
- Clinicians and staff from primary care practices
- Hospital IT leadership
- Parent organization IT leadership

- Practice-based IT liaisons

The names of work group members and the organizations they represent should be submitted to the Blueprint for Health bi-annually with the progress reports. All meeting minutes detailing the individuals in attendance, organizations the attendees represent, and content of the meeting should be submitted to the Blueprint with expenditures reports, or at a minimum with the bi-annual progress reports.

The **Advanced Primary Care Practice internal teams** are interdisciplinary teams in the primary care practices. They will work on continuous quality improvement including but not limited to optimizing guideline based health maintenance and preventive care; coordination and transitional care strategies with the hospital, community health team, and other community providers; panel management and outreach targeted towards prevention; improved patient self management and decision support; movement towards NCQA PCC-PCMH certification; and optimizing the effective utilization of the Blueprint Registry. Regular meetings of the internal quality improvement teams (e.g. every 1-2 weeks, but no less frequently than monthly) are more likely to result in more seamless high quality care for patients.

Depending upon local availability, Practice Facilitators through the **Expansion and Quality Improvement Program (EQuIP)** will be available to the primary care practices. It is expected that the practice will make every effort to work with these skilled personnel to advance the work of the practice-based quality improvement teams.

4   Design & Implementation Process

4.1   *Integrated Health Services Planning*

With the guidance of the local Blueprint project manager, an Integrated Health Services (IHS) workgroup will be established. The IHS workgroup is responsible for planning community health team composition and implementing CHT operations, strategies for transitions of care and coordinated health services (medical and non-medical), and sequencing for NCQA PPC-PCMH scoring of local participating primary care practices. This multi-stakeholder group (see list in section 3.3) will use assessments of the community's resources and needs to determine the appropriate composition of the CHT and strategies for well-coordinated health services. The gathering and collaborative dialogue of this group is essential in order to implement an effective CHT that is responsive to the local community's needs and strengths.

The Project Manager should identify all primary care practices, (internal medicine, family practice, pediatrics, and obstetrics and gynecology) in the HSA and determine and encourage their interest in participation in the local Blueprint initiative. Representatives from each practice should be invited to join the work group. The current status of participation of all practices should be documented; including demographic information, NCQA PPC-PCMH certification, participation in quality improvement projects, HIT implementation and multi-insurer payment (see Attachment B for a list of data elements).

The Project Manager will use the list projects and their current level of participation as a living reference, updating the work group on the status of the local practices, which will in turn inform the proportional establishment or growth of the CHT.

4.2   Community Health Team Development

The Community Health Team (CHT) is a multidisciplinary team that partners with primary care offices, the hospital, and existing health and social service organizations. The goal is to provide citizens with the support they need for well coordinated preventive health services, and, coordinated linkages to available social and economic support services. The CHT is flexible in terms of staffing, design, scheduling and site of operation, resulting in a cost-effective, core community resource which minimizes barriers and provides the individualized support that patients need in their efforts to live as fully and productively as possible. The CHT functions as extenders of the Advanced Primary Care Practices they support and their services are available to all patients (no eligibility requirements, prior authorizations, referrals or co-pays). Vermont's major commercial and public insurers finance the CHT as a shared resource.

4.2.1 Planning

The Integrated Health Service workgroup (IHS workgroup) will develop a plan that describes the design and make up of the Community Health Team (CHT). Each CHT is comprised of new positions paid for by the insurers as well as professionals who already deliver services in the local area. For the purposes of discussion the new positions paid for by insurers are considered the core CHT. The core CHT working with existing providers in the community forms a broader functional CHT, leveraging the investment in the core CHT to provide citizens with reliable and well coordinated access to a broad range of health and human services. CHTs are designed based on community specific needs (both of the patients and primary care practices), usually including but not limited to nurse care managers, behavioral health specialists, health coaches, panel managers, and tobacco cessation counselors. There is a list of suggested CHT participating professionals in § 705 (a).

To ascertain the community specific needs the IHS workgroup should identify current health services and existing gaps for patients and providers in participating primary care practices and the surrounding community. Based on the information obtained, the group will build the foundation of the community health team by working together to determine how existing services can be reorganized and what new services are required to better meet the needs of patients and providers. Funding from the insurers is available to hire core CHT personnel to fill the service gaps, coordinate services, and assist with panel management.

In addition to planning how they will organize the health services in their community and the composition of their CHT, the IHS workgroup must select a lead administrative organization(s) to hire the core CHT members (Section 3.1). While the core CHT is

administered by a particular lead organization, it must in all cases extend beyond that organization to work across unaffiliated organizations and entities.

In addition to the core CHT members, CHTs are expected to include additional members that create a broader functional CHT. Where they are available, CHTs should include Department of Health local district office staff and Department of Vermont Health Access Care Coordinators.   Representatives from other organizations should also be included, such as the local Designated Agencies and Community Mental Health Centers, Visiting Nurse and Home Health organizations, Area Agencies on Aging, Seniors Aging Safely at Home (SASH) program staff, and Children's Integrated Services providers. The HSA Project Manager, IHS workgroup, and core CHT should actively seek out local community health and human service programs to ensure effective coordination. CHTs are expected to have interaction with state and regional staff of the Agency of Human Services who work on programs targeting specific sub-populations within the community the CHT serves such as the Children's' Integrated Services teams. Staff from these programs, which often include additional case management or care coordination capacity, are examples of the extended "functional team" expected in successful CHT implementation.

The IHS workgroup and lead administrative entity must summarize their CHT plan in a written description of how the CHT will integrate into advanced primary care practices, job descriptions for CHT members, and a plan for CHT oversight. An MOU or agreement between the primary care practices and the CHT hiring entity, must exist prior to hiring the CHT and must be presented with the CHT Application (see section 4.2.3 Community Health Team Application and Designation Process)

4.2.2 Community Health Team Scale

A core Community Health Team unit is established based on a ratio of five full time equivalent staff (5 FTEs) annually per 20,000 persons served in the CHT's defined primary care service area. These 5 FTEs should all be providers to optimize the support services that are offered to citizens. The costs of the core CHT units will be shared by Vermont's commercial and public insurers (Medicare and Medicaid) at a cost of $350,000 per 5 FTEs.

The number of core CHT members hired in each geographic service area is scaled up or down, depending on the size of the population served by participating Advanced Primary Care Practices. An Advanced Primary Care Practice is a primary care practice that has completed all eligibility requirements including achieving NCQA PPC-PCMH recognition at Level 1 or higher. The population served is determined by the number of patients that have had a visit to any of the participating Advanced Primary Care Practices in the last 2 years.

4.2.3 Community Health Team Application and Designation Process

Once a CHT plan has been developed, the lead administrative entity
should submit two signed copies of the Community Health Team application to:

Attn: Blueprint Associate Director
Department of Vermont Health Access
Vermont Blueprint for Health
312 Hurricane Lane, Suite 201
Williston, VT 05495

The application for designation as a Community Health Team is available at
http://hcr.vermont.gov.

DVHA will acknowledge receipt of the preliminary CHT application by email and will add
the community and lead organization to its statewide database of prospective and active
Community Health Teams.

Applications must include:
- List of community partners who make up the Integrated Health Services Workgroup
  and Health Information Technology Workgroup, including but not limited to aspirant
  and / or Certified Medical Homes, other local health care and human services
  professionals and provider organizations
- Narrative section describing how the CHT intends to meet the expectations listed in 18
  V.S.A. § 704.
- CHT plan indicating both core CHT staff funded by insurers and other functions to be
  performed through collaboration with existing providers in the geographical service
  area (functional CHT), a copy of a partners letter or CHT MOU, and a description of how
  the CHT will be embedded within the primary care practices and other health and social
  services, and a timeline for expanding to serve all willing primary care practices within
  the proposed service area by October 1, 2013.
- Documentation of the ways in which the CHT will coordinate across the health care
  continuum, including integration of the CHT efforts with rehabilitative and long term
  care providers (in both home and institutional settings), mental health, behavioral
  health, and substance abuse providers, and providers of integrated and complementary
  medicine.

Before designation and multi-insurer funding is available to support core CHTs, the lead
administrative entity must provide evidence of formal partnerships with local aspirant
and/or NCQA PPC-PCMH recognized Advanced Primary Care Practices through:

a) Validation by NCQA of participating primary care practices' PCC-PCMH score of 25 or
   higher and compliance with a minimum of 5 must pass elements.
b) A Letter of Support from the lead Administrative entity to assure CHT support for the
   primary care practice once the practice meets eligibility requirements as an Advanced
   Primary Care Practice.
c) A Letter of Commitment from the primary care practice to work with the CHT and the
   lead Administrative entity, and to provide their patients with well coordinated
   preventive health services.

d) A Memorandum of Understanding or similar document executed between the practice and the lead Administrative entity may be substituted for b and c.
e) In order to be eligible for CHT payment, all APCPs will need to have met the requirements outlined in Section 4.5.4 of this document.

4.3   Advanced Primary Care Practice

4.3.1 Definition

An Advanced Primary Care Practice is a primary care practice that has completed the program eligibility requirements outlined in this document including achieving official recognition (Level 1 or higher) based on National Committee for Quality Assurance (NCQA) Physician Practice Connections – Patient Centered Medical Home (PPC-PCMH) standards. The eligibility requirements to qualify as an Advanced Primary Care Practice are listed in Checklist in Appendix A.

4.3.2 Quality Improvement Team

Each primary care practice should develop an internal multi-disciplinary quality improvement team to work on continuous quality improvement including but not limited to working with the CHT to coordinate services including effective transitions from acute episodic care to preventive care, planned visits, patient self-management support, decision support, and implementation and effective utilization of the health information architecture and NCQA PPC-PCMH recognition. This serves as the practice level component of the Expansion and Quality Improvement Program (EQuIP). Smaller primary care practices, where multi-disciplinary teams are impractical, should designate a lead clinician and/or staff that will guide their internal quality improvement processes.

These practice-based quality improvement teams should be representative of the staffing in the primary care practice and meet regularly (no less then monthly) to review operations and outcomes measures (e.g. Blueprint registry), and to plan data-guided ongoing improvement. Sample composition should include one or more primary care providers, practice managers, nurses, office support staff and a patient/consumer. It is strongly recommended that a primary care provider participate in the Integrated Health Services Workgroup, connecting the larger hospital service area planning with the individual primary care practice planning.   As part of EQuIP, the Blueprint's trained Practice Facilitators will be available to the practice-based quality improvement teams as much as facilitator staffing allows.

Each advance primary care practice quality improvement team should record their practice demographics using an excel spread sheet provided by the Blueprint, including the name of a primary contact person for the practice (see Appendix B for a list of data elements; download the spreadsheet from http://hcr.vermont.gov). An updated spreadsheet should be sent to the local Blueprint project manager any time significant staffing or services are changed and during any NCQA PPC-PCMH scoring or rescoring.

4.3.3 NCQA Scoring

Overview: The Blueprint uses the National Committee for Quality Assurance (NCQA) Physician Practice Connections – Patient Centered Medical Home (PPC-PCMH) standards to evaluate and score practices (as well as the other requirements) to become and to maintain their status as Blueprint Advance Primary Care Practices. A copy of the standards can be found on the NCQA website at http://www.ncqa.org.

The Vermont Child Health Improvement Program (VCHIP) at the University of Vermont College of Medicine works with the aspirant advance primary care practices to complete a practice site assessment and scoring utilizing the NCQA PPC-PCMH framework. In order to be recognized for enhanced payment by insurers and to receive that payment, practices <u>must</u> be scored by VCHIP. The VCHIP assessment is then submitted to NCQA for validation at the national level. The Blueprint pays for the cost of VCHIP assisting with assessment. The practice is responsible for paying the required fee to NCQA for their review, validation, and recognition.

The overarching goal, mandated in Act 128, is to extend the program to all willing primary care providers by October 2013. In addition, the law states that at least 2 practices per HSA will be fully operational APCPs by July 2011. The following program priorities, based upon this guiding statute, will be used to sequence scoring of eligible practices.
   1. The primary care practice site must meet eligibility requirements as outlined in this manual (Appendix A)
   2. Priority will be given to willing and <u>eligible</u> practices in Hospital Service Areas (HSAs) that do not have a minimum of 2 participating practices.
   3. Priority within HSAs will be given to willing and <u>eligible</u> practices that will help active participation reflect the mix of primary care practice types in the geographic area (e.g. independent practices, hospital and/or parent organization-owned practices, Federally Qualified Health Centers, practice size).

The first step in the NCQA PPC-PCMH scoring process is to assess the current (baseline) status of the practice based on the NCQA scoring elements and standards. The practice-based Quality Improvement (QI) teams can complete the assessment sheet (available at http://hcr.vermont.gov). As the QI team works through the assessment it is helpful to prepare a binder of the corresponding written policies, procedures and other documenting evidence that a specific element is met. The binder will later be used by VCHIP to verify successful completion of the individual competencies.

Once the assessment is complete, the practice's QI team can identify elements and standards that are lacking and would prevent the practice from scoring in that area. The QI team should prioritize the NCQA PPC-PCMH elements and standards they would like to address identifying those they feel are essential to complete prior to the first NCQA scoring and those that will be addressed subsequently. In prioritizing the group's efforts it is helpful to rate the elements and standards based on those that are more urgent (e.g. necessary for clinical operations), important (such as the "must pass" elements for NCQA) and easiest to achieve (those that would require little effort and positively impact patient

care and NCQA score). Once a draft list of priorities has been developed it should be posted for feedback of other practice staff members who are not on the Quality Improvement team.

Once decisions have been reached regarding the elements that need to be achieved prior to NCQA PPC-PCMH scoring, the quality improvement team should begin to use rapid process improvement cycles utilizing the PDSA (plan, do, study, act) model to make the necessary changes. This may be as simple as mapping and documenting an "everybody knows it" policy, or may be more difficult, such as changing clinical flow and job roles. Practice facilitators contracted through the Blueprint will be available as possible to provide technical assistance. Practices should contact the local Blueprint project manager to request the assistance of a practice facilitator.

The local project manager will complete and send the Blueprint NCQA assessment request form (available at http://hcr.vermont.gov) to UVM VCHIP to put the practice in the queue.

The University of Vermont College of Medicine (UVM) Vermont Child Health Improvement Program (VCHIP) or other official scoring entity will conduct official scoring of practices as designated by the Blueprint. As necessary, the HSA project manager will facilitate contact between primary care practices and the UVM VCHIP NCQA scoring team. UVM VCHIP (or other official scoring entity) will acknowledge receipt of the application to be scored by email and will work with the practice site to schedule the NCQA PPC-PCMP scoring date. The following steps will help prepare the practice for scoring.

- Identify a staff and a clinical champion (should be part of IHS planning group)
- Complete practice demographics (feedback to IHS planning group)
- Using the NCQA guide, identify what is and is not in place in the practices to meet NCQA standards.
- It is recommended that the practice assemble a practice quality improvement team that reflects the practice staffing structure to decide which of the standards and elements will not be met and which to work on before and after NCQA scoring
- Develop a practice plan for improvement (e.g. PDSA cycles) prior to scoring based on practice priorities.
- Prior to scoring, document policies or procedures that are currently in place in the NCQA binder
- Schedule a scoring date with the Blueprint- approved scoring entity. When scorers are not readily available, scheduling priority will be based on the criteria listed in 4.3.3.

In order to be officially recognized by the NCQA and eligible for enhanced payments as an Advanced Primary Care Practice, Vermont practices must achieve at least Level 1 recognition equivalent to a minimum of 25 of the 100 possible maximum points, and pass at least 5 of the 10 "must pass" elements.

4.3.4 Attribution & Enhanced Payments

The enhanced per person per month (PPPM) payment for Advanced Primary Care Practices is intended to help the practice, in conjunction with the Community Health Team, provide well coordinated preventive health services for all their patients. At this time the enhanced payment is in addition to any payment that the practice receives based on existing agreements (e.g. Fee for Service).

The enhanced PPPM payment is based on the number of patients that are attributed to the practice by each insurer. The attribution method used by all insurers is intended to determine the practice's active caseload. At present, commercial insurers attribute all patients that have had a visit (Evaluation & Management Code) to the practice in the last 24 months. Vermont Medicaid attributes all patients that have had a visit to the practice in the last 12 months. Vermont's insurers have elected to apply these look back periods based on their beneficiaries' demographics, recommended health maintenance, and health related risks. It is anticipated that Medicare (as part of the Multi-payer Advanced Primary Care Demonstration in Vermont) will propose an attribution of all patients that have had a visit to the practice in the last 12 months. These definitions are subject to change based on the ongoing work in the Blueprint Payment Implementation Work Group, the Blueprint's other advisory groups, and planning discussions with CMS if Vermont is selected as part of the MAPCP Demonstration.

The enhanced payment amount ranges from $1.20 PPPM to $2.39 PPPM (see table below). Payment varies based on the practice's NCQA PPC-PCMH score starting at 25 points and increasing or decreasing based on every 5 point increment the practice achieves on the NCQA PPC-PCMH scoring scale. Although all scores must be validated by NCQA, practices are considered NCQA scored for payment purposes once VCHIP has completed their assessment.   Practices can elect to be re-scored every 6 to 12 months based on availability of Blueprint approved supported scorers (currently through VCHIP).   The use of consistent and independent scoring methodologies is important for the credibility and integrity of the program, and for evaluation purposes.

**Provider Payment Table
($PPPM for each provider)**

NCQA PCMH Points	Average PPPM Payment
0	0.00
5	0.00
10	0.00
15	0.00
20	0.00
25	1.20
30	1.28
35	1.36
40	1.44
45	1.52
50	1.60
55	1.68
60	1.76
65	1.84
70	1.92
75	2.00
80	2.07
85	2.15
90	2.23
95	2.31
100	2.39

Requires 5 of 10 must pass elements

Requires 10 of 10 must pass elements

4.3.5 Payment Reforms

General: Two new forms of payment shall be received from the insurers to support high quality advanced primary care and well coordinated health services. Medicare announced its decision to join Vermont's state led efforts as part of the Multi-payer Advanced Primary Care Demonstration program on November 16, 2010, completing the list of major insurers participating in the payment reform described in this section.

4.3.5.1 Enhanced Payment to Advanced Primary Care Practices

Based upon the NCQA PPC-PCMH recognition score, as described in Section 4.3.4, the insurers will multiply the number of their attributed beneficiaries by the appropriate dollar amount to generate a Per Patient Per Month (PPPM) payment for each practice. This will be sent directly to the practice or parent organization.

At least 2 months prior to the NCQA PPC-PCMH scoring by VCHIP, each primary care practice will receive an initial attribution list of current active patients from each participating insurer (commercial and public). The practices have the next 30 days to review these attribution lists and reconcile identified discrepancies in an iterative process. Within 30 days of agreement on the attribution, the Per Patient Per Month payments shall begin. Updates to the patient panel lists should be done on an annual basis.

The definition of a "current active patient" is as follows:

Commercial Insurers: The patient must have had a visit in the primary care practice (Evaluation & Management Code) within the 24 months prior to the date that the attribution process is being conducted. The patient is attributed to the last practice where they had an E&M coded visit. Attribution is refreshed routinely (varies among insurers).

Public Insurers (Medicaid only): The patient must have had a visit in the primary care practice (Evaluation & Management Code) within the 12 months prior to the date that the attribution process is being conducted. The patient is attributed to the last practice where they had an E&M coded visit. A process to conduct the attribution process on a routine basis is currently being developed (e.g. monthly).

Each insurer will send a list of the number of attributed patients to each Advanced Primary Care Practice (or parent organization) when the attribution is first conducted or refreshed, providing an opportunity to reconcile differences. The insurer and practice should agree on the number of attributed patients within 30 days of the date that the insurer sends an attribution list to the practice in order to support an efficient and uninterrupted payment process.

4.3.5.2 Community Health Team Payments

The insurers will share the costs associated with the core Community Health Team staffing. The number of full time equivalent (FTE) CHT staff members is based on a ratio of 5 FTEs for a general population of 20,000. $350,000 will be allocated for each 5 FTE-member CHT unit per year. Insurers will send their share of CHT costs to the Administrative entity or

entities in each HSA that are responsible for hiring CHT members.   At present, insurers
share the cost of the CHT units in an agreed-upon shared cost structure.   The Blueprint
Payment Implementation Workgroup (Section 2.3) will be examining alternative schemes
(e.g. proportional) based on program experience including how the CHT time and activity is
utilized.

Insurers and practices must agree on the size of the general population served by
participating Advanced Primary Care Practices. This will allow a determination of the
number of CHT units that will be deployed to serve the population served by the practices
(5 FTEs / 20,000 patients). To determine the size of the population that will be served, and
the number of CHT members that will serve the population, participating practices will
report the number of active patients that they have seen in their practices in the previous
two years.   One of the goals of the CHT is to work with practices to optimize the number of
patients that engage in preventive care and recommended health maintenance. The 24
month look back period is an attempt to estimate the number of active patients in a
practice that can potentially be engaged in preventive care with effective outreach from
Advanced Primary Care Practices and Community Health Teams.

In parallel to the PPPM attribution process, the insurers will verify the list of attributed
active patients for CHT scale planning 2 months prior to the start date of the CHT's clinical
operations. This list will be identical for the commercial insurers and will differ for the
public insurers' lists generated for the PPPM attribution. <u>All patients seen within 24
months by the aspirant APCP will be counted regardless of insurer for this specific purpose.</u>

4.4   Transitions of Care

The overall design of the Blueprint Advanced Primary Care Model is intended to provide
patients with seamless and well coordinated health and human services. This includes
transitioning patients from patterns of acute episodic care to preventive health services.
This is essential in order to improve health outcomes, improve control over the rate at
which healthcare costs are growing, and to sustain investment in Advanced Primary Care.
It is strongly encouraged that the IHS workgroup, Advanced Primary Care Practices, CHT
members, Hospital leaders, and other community service providers work together on
consistent and systematic strategies for transitioning patients from acute episodic care to
preventive health services. Well structured follow up and coordination of services after
hospital based care has been shown to improve health outcomes and reduce the rate of
future hospital based care for a variety of patient groups and chronic health conditions (e.g.
reduce emergency department visits, hospital inpatient admissions, re-admissions).   These
outcomes are essential in order to demonstrate the health and financial impacts that
necessary for sustainability and ongoing investment in Advanced Primary Care Practice.

It is also recommended that practices, CHT members, hospital staff, and other community
service providers work closely to implement transitional care strategies that keep patients
engaged in preventive health practices and improved self management. A goal of the
Blueprint model is seamless coordination across the broad range of health and human

services (medical and non-medical) that are essential to optimize patient experience, engagement, and to improve the long term health status of the population.

Blueprint staff and practice facilitators will be available to work with practices, CHT members, hospital staff, and other community service providers to assist with researching and planning transitional care strategies that have been shown to be effective.

4.5   IT Infrastructure to Support Coordinated Services and a Learning Health System

4.5.1 Introduction

The overarching goal of the Blueprint model is to provide citizens with high quality well coordinated health services.   Advanced Primary Care Practices, Community Health Teams, and supportive multi-insurer payment reforms provide a unique opportunity to achieve this goal. A robust health information infrastructure, however, is absolutely essential to realize the true potential of these reforms.   The Blueprint Advanced Primary Care Model includes a health information architecture that is designed to support guideline-based care and coordinated health services for individuals and populations, as well as ongoing quality improvement, a dynamic learning health system.

The Blueprint has put in place a web based central registry (DocSite) that is designed to support each of these functions.   The registry can produce individualized visit planners based on a patient's age, gender, and diagnoses. The registry's visit planners are guideline-based and designed to support age and gender appropriate health maintenance as well as care for chronic disease. This allows the registry to support individual patient care in practices that don't have an electronic medical record (EMR), or that choose to use the visit planners even if they do have an EMR which does not have planned visit functionality.

The registry also has flexible and dynamic outreach reporting so that practices and CHTs can pull reports to identify populations of patients based on particular risk factors or measures of health status. This flexible reporting functionality is specifically designed to help clinicians and health services providers with outreach and population management (panel management), without a need for technical and programming expertise. Experience to date suggests that this type of flexible reporting will be valuable to practices, organizations, CHTs and others, whether or not they have an EMR.

An essential advantage of the registry is that it can support coordinated health services across independent practices and organizations that may each have their own EMR or tracking system. With the registry in place, CHTs, Medicaid Care Coordinators, and other service providers have a system to use on a community wide basis to pull reports, track coordination of services, and assist individuals with guideline-based care.

In addition, the registry has flexible performance reporting, with the ability to support evaluation and comparative reporting at a State, Hospital Service Area, Organization, Site, or provider level. The reporting functionality provides substantial information on the rates

that the population is meeting health outcomes goals, or the rate that clinical process goals are being met. The functionality then allows providers to 'click' and bring up the patients that are not "at goal"… a simple one or two step process that links performance and outreach, or, a one or two step process that links population level measures to actionable information for individuals. Furthermore, the readily available performance reports can be used by practices, community health teams and other Hospital Service Area stakeholders to support ongoing quality improvement. The combination of this type of reporting, and the availability of skilled Blueprint facilitators, is intended to support ongoing quality improvement activities, or a true learning health system that continuously improves itself. The Advanced Primary Care Practice based quality improvement teams (Section 4.3.2) and the Integrated Health Services workgroups (Section 4.1) are forums where a learning health system can come alive, supported by the Blueprint's reporting and evaluation infrastructure.

The value of the registry depends on the quality and quantity of the data that is being transmitted to it. The utility and use of the registry also depends on providers being able to use it without having to enter data into more than one electronic system. For example, if a site has an EMR, their providers should be able to use their EMR for patient care and have access to the registries reporting without having to enter the data into the registry as well.

This requires the ability to transmit common data elements, from multiple sources, into the Blueprint registry. The Blueprint is working closely with the registry vendor (DocSite) and Vermont Information Technology Leaders, Inc. (VITL) to build an infrastructure that transmits data from various sources into the registry. This involves detailed and complex work with practices, organizations, and hospitals. As part of readiness and implementation, it is essential for key stakeholders in each Hospital Service Area (HSA) to work with the Blueprint, VITL, and the registry vendor to establish the linkages and data transmission that can make the health information architecture most useful, and optimize the use of guideline-based data elements to guide preventive health services.

4.5.2 Implementation

With the guidance of the Blueprint project manager, a Health Information Technology (HIT) workgroup will be established in each HSA to support implementation of the HIT architecture. This group will work closely with VITL Project Management and the Blueprint Registry vendor (DocSite) to plan the work for optimizing the use of guideline based data elements in EMRs, extracting the core data elements from sources such as EMRs and hospital data warehouses, and transmitting the core data elements through the VITL Health Information Exchange Network (HIE) to the registry. The following steps are involved in this process.

1. If a practice or organization is using an EMR, the first step is to map the source data system (EMR, Hospital warehouse) against the core Blueprint Registry data dictionary to determine which data elements and answer options are already part of the source system, and to determine the differences in the data elements and answer options if

they are indeed in the source system. This work will be done by the registry vendor (DocSite), which has a clinical and technical understanding of the core data elements, as well as an understanding of the importance of workflow in a clinical setting. DocSite is funded for this work by their contract with the State of Vermont. The practice or clinical organization will need to dedicate personnel time to assist DocSite with this task.

2. DocSite will work with their key contact in the practice or organization to develop a plan to optimize use of guideline based core data elements in the practice's EMR and in the registry. This may involve several options depending on what is found in Step 1 (above). For example, this could involve minor adjustments to some answer options in the EMR templates, or it may involve a receiver interface at DocSite that translates the answer options into categories that can be used in the registry. DocSite is funded for this work by their contract with the State of Vermont. The practice or clinical organization will need to dedicate personnel time to assist DocSite with this task.

3. VITL will work with the key IT contact in each practice or organization to conduct a Technical Assessment. This is an overview of the technical systems, servers, Practice Management and Electronic Health Record systems. It provides VITL with detailed information on version numbers, providers and number of patients. VITL is funded for this work by their contract with the State of Vermont. The practice or clinical organization will need to dedicate personnel time to assist VITL with this task.

4. VITL will work with the appropriate vendor for the source system (EMR, data warehouse) to plan and develop an interface that can transmit all of the Blueprint core data elements from the source system to the VITL HIEN and the registry. The interface will have the capacity to transmit all the data elements even if they are not available in the source system so that the interface can support modifications and enhancements that may be made to the system. VITL is funded for this work by their contract with the State of Vermont. The practice or clinical organization will need to dedicate personnel time to assist VITL with this task.

5. VITL will establish a VHIE Connection. This is a Virtual Private Network connection between your practice or organization and the VITL HIEN. This Virtual Private Network will be set up by VITL and EHR vendor to pass your data to the VHIE and or the Blueprint Registry. VITL is funded for this work by their contract with the State of Vermont. The practice or clinical organization will need to dedicate personnel time to assist VITL with this task.

6. Testing the data quality is essential. There are multiple levels of testing that take place during the Implementation Phase. These include both Integration testing and User Acceptance Testing. Integration testing is performed by the vendors to ensure that the data is correctly leaving the local system and updating the Blueprint Registry appropriately. The second, the User Acceptance Testing, is where members of the practice or organization participate in testing the system. With the help of DocSite and VITL, the practice will develop a plan to test various use cases to ensure that the data is

appropriately updating the Registry.

7. Training to use the registry reporting system will be provided on site by the Blueprint Registry team (DocSite/Covisint.) This is generally a one or two day training event that will be coordinated with the practice staff before the end of the project. This training will occur after all the practice's data is live enabling the practice itself to report off its own data. Blueprint facilitators are also being trained to assist with use of the registry reporting on an ongoing basis.

8. Technical support for the registry will continue after the implementation. After the system is live and all the data is flowing to the Blueprint Registry, a Support Document will be provided with instructions on who to call in case of a problem with the system or data. This document will outline how best to report a problem and when support providers are available for assistance. The registry vendor (DocSite) will supply this document.

4.5.4 Implementation - Agreements

In order to be eligible as an Advanced Primary Care Practice, practices or their parent organization will need to have the following required agreements and documentation regarding optimizing the use of health information and HIT connectivity. Samples of these agreements can be found at www.vitl.net. Work will also need to be underway or planned and scheduled to complete the implementation steps outlined above. This requirement is subject to the availability and responsiveness of the Blueprint Registry vendor and VITL, and can be waived at the discretion of the Blueprint Director or Associate Director if it is determined that there exist undue delays, beyond the control of the practice or parent organization.

- Blueprint Registry Business Associate Agreement. A legal document between you and the Blueprint Registry vendor (DocSite/Covisint) allowing them to store your protected health information. This will be provided by DocSite.

- VITL Project Charter which is a high-level document that details the purpose of the project, the deliverables, and the cost. This document is prepared by VITL and is reviewed by all parties. You will sign off on the Charter to mark the beginning of the interface work. This document will be provided by VITL.

- VITL Business Associate Agreement. This is a comprehensive connectivity agreement between VITL and your practice. This will be provided by VITL.

- VITL Memorandum of Understanding that outlines the responsibilities and processes regarding reimbursement for interfaces developed to send your data to the Blueprint Registry. This document will be provided by VITL.

Appendix 1 - Checklist

1. Hospital Service Area Organization

- ✓ Form a local planning committee
- ✓ Appoint an administrative entity
- ✓ Identify local Blueprint leadership team
  - Retain an overall project manager
  - Identify a clinical leader
  - Identify a health information technology leader
- ✓ Convene and maintain Integrated Health Services (IHS) Workgroup
- ✓ Convene and maintain Health Information Technology (HIT) Workgroup
- ✓ Submit two signed copies of the MAPCP model community application
- ✓ Enter into an agreement with DVHA agreeing to:
  - Participate in the statewide evaluation
  - Facilitate local connectivity to the Blueprint registry and Vermont Health Information Exchange (VHIE)
  - Document and maintain an implementation plan and timeline consistent with the Blueprint for Health Manual including the development and expansion of the CHT; connectivity with the VHIE and utilization of registry; and progress of all primary care practices, hospital and privately owned, toward becoming Advanced Primary Care Practices (APCPs)
  - Update the Blueprint database with current information about the status of health information technology, integrated health system and primary care practice implementation
  - Submit bi-annual progress reports by April 30 for the period of October 1 to March 31; and November 1 for the period of April 1 to September 30
  - Submit meeting minutes for workgroups with expenditures reports or at a minimum bi-annually with the progress reports including the individuals in attendance, organizations the attendees represent, and content
- ✓ Ensure that the timelines of the IHS , HIT, and advanced primary care practice planning groups are synchronized
- ✓ Participate or designate a representative from the HSA to participate on the state Expansion Design and Evaluation Committee and Payment Implementation Workgroup

2. Integrated Health Services Planning

- ✓ Ensure that all local primary care practices are informed of the local Blueprint initiative; documenting their participation and progress toward becoming an advanced primary care practice including a timeline of when each practice will achieve NCQA PPC-PCMH recognition requiring expansion of the CHT
- ✓ Ensure active participation in CHT planning of primary care practices and representative service organizations in the community
- ✓ Identify current health services and existing gaps in services for patients and providers in local primary care practices (aspirant APCPs)
- ✓ Determine how existing services can be reorganized to fill the gaps in services

- ✓ Identify the personnel needed to address the remaining gaps and develop job descriptions for this 'core community health team'
- ✓ Identify the functional CHT consisting of existing professionals and services in the area that support the integrated efforts of the team, such as dieticians, pharmacists, exercise physiologists, diabetes and asthma educators, tobacco cessation counselors, and trained peer mentors among others.
- ✓ Identify a lead organization and contact to become the CHT hiring entity and a structure for CHT oversight
- ✓ Define how the CHT will integrate into advanced primary care practices
- ✓ Define the ways in which the CHT will coordinate across the health services continuum, including integration of the CHT efforts with rehabilitative and long term care providers (in both home and institutional settings), mental health, behavioral health, and substance abuse providers, providers of integrated and complementary medicine and economic and social services
- ✓ Develop a written CHT plan
- ✓ A Letter of Support from a local entity recognized by the Blueprint as a Community Health Team lead sponsor for an active or developmental Community Health Team AND a Letter of Commitment to a local entity recognized by the Blueprint as a Community Health Team lead sponsor for an active or developmental Community Health Team; or Memorandum of Understanding or similar document executed between the practice and Community Health Team lead sponsor
- ✓ Document NCQA PPC-PCMH scoring by UVM of participating primary care practices of at least Level 1
- ✓ Submit two signed copies of the Community Health Team application to the Blueprint
- ✓ Two months prior to forming the CHT, work with commercial and public insurers to come to agreement on CHT attribution
- ✓ Hire the CHT
- ✓ Continuously expand until serving all recognized APCPs
- ✓ Create a process for seamless transitions in care

3. Advanced Primary Care Practice

3.1. Quality Improvement

- ✓ Develop an internal multi-disciplinary quality improvement team, which meets regularly (no less than monthly) to work on health information technology implementation, and improving patient care, practice workflow and NCQA PPC-PCMH recognition
- ✓ Provide practice demographics to the HSA Blueprint project manager

3.2. NCQA Certification

- ✓ Complete the NCQA PPC-PCMH assessment sheet
- ✓ Prepare a binder of the written policies, procedures and other documenting evidence that a specific NCQA PPC is met
- ✓ Identify what is and is not in place in the practices to meet NCQA standards

- ✓ Prioritize the standards that are lacking that the practice would like to address, identifying those they feel are essential to complete prior to the first NCQA scoring and those that will be addressed subsequently
- ✓ Post draft list of priority quality improvement projects for feedback of other practice staff members who are not on the QI team
- ✓ Document a quality improvement timeline based on the priority list of QI projects
- ✓ Use rapid process improvement cycles, PDSAs (plan, do, study, act) to make the necessary changes
- ✓ Post the timeline and progress updates for practice staff members who are not on the QI team
- ✓ Submit the NCQA PPC-PCMH Assessment Request form through the project manager to VCHIP 6 months prior to goal date for NCQA PPC-PCMH scoring

3.3. Integrate CHT into practice

- ✓ Participate in the CHT planning process
- ✓ CHT agreement/MOU

3.4. Health Information Technology

3.4.1. Required Prior to Payment

- ✓ Blueprint registry business associate agreement
- ✓ VITL project charter
- ✓ VITL business associate agreement
- ✓ VITL memorandum of understanding

3.4.2. Demonstrate Progress Prior to Payment

- ✓ Assist DocSite with mapping data elements
- ✓ Assist DocSite in optimizing data elements
- ✓ Participate in VITL technical assessment
- ✓ Assist VITL and EMR vendor with Vermont Health Information Exchange (VHIE) interface
- ✓ Assist VITL with VHIE connectivity
- ✓ Data testing
  - • Integration testing done by EMR vendor
  - • Conduct user acceptance testing
- ✓ Registry training

3.5. Attribution Agreement

- ✓ Contact the insurers 2 months prior to recognition as an Advanced Primary Care Practice
- ✓ Review the attribution list and come to agreement on attributed patients at least 1 month prior to payment

Prior to commencing enhanced payments for primary care practices or the CHT, NCQA scoring, CHT planning, and IT agreements must all be completed. It is the responsibility of the project manager to ensure these activities are synchronized.

Appendix 2 – Hospital Service Area Data Elements

Advanced Primary Care Practice Demographics
Hospital Service Area
Organization or Practice
Site
Address
MAPCP Status
PCP (MD, DO)
PCP (APRN)
PCP (PA)
PCP (ND)
Total # PCPs
Psychiatrists
Psychologists
LSW (mental health counselors)
Total # Mental Health
Staff (RNs)
Staff (LPN)
Staff (LSWs)
Staff (MAs)
Staff (Clerical)
Staff (other)
Staff Other (Type)
Total # Staff
Total # Unique Patients with a Visit to Practice in Last 24 Months
NCQA Preparation Status
Advanced Primary Care Quality Improvement
NCQA Scoring Scheduling
NCQA Score
Date of NCQA Score
Primary Medical Record
Advance Primary Care Practice Information Technology
EMR updates
Interfaces
Data to Registry
Percent of Data Elements to Registry
Registry Use (patient care)

Registry Use (panel management)
Registry Use (evaluation & QI)
Advanced Primary Care Practice Reimbursement
Attribution Status
Attributed BCBS Pts for PPPM
Attributed Cigna Pts for PPPM
Attributed MVP Pts for PPPM
Attributed VMC for PPPM
Attributed Medicaid Pts for PPPM
Attributed Medicare Pts for PPPM
Total # Attributed Pts for PPPM
Quality Improvement Agreement
BCBS PPPM Agreement
Cigna PPPM Agreement
MVP PPPM Agreement
VMC PPPM Agreement
Medicaid PPPM Agreement
Medicare PPPM Agreement
Community Health Team Planning
CHT Planning
HSA CHT Administrative Entity
Administrative Entity Address
CHT Hiring Entity
CHT Memorandum of Understanding or Letters of Support
DVHA CHT Administrative Entity MOU
CHT FTEs Planned
CHT FTEs Hired
Community Health Team Reimbursement
BCBS CHT Administrative Entity Agreement
Cigna CHT Administrative Entity Agreement
MVP CHT Administrative Entity Agreement
VMC CHT Administrative Entity Agreement
Medicaid CHT Administrative Entity Agreement
Medicare CHT Administrative Entity Agreement

Hospital Service Area Organization
Administrative Entity
Administrative Entity Address
Blueprint Administrative Entity Agreement
Blueprint Implementation Work plan
Number of Primary Care Practices in HSA
Number of Participating Primary Care Practices
Number of Recognized Advanced Primary Care Practices
Percent of Primary Care Practice Involved
Percent of Primary Care Practices Recognized as Advanced Primary Care Practices