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INNOVATION PROFILE

# Vermont's Blueprint For Medical Homes, Community Health Teams, And Better Health At Lower Cost

**SYSTEM** **The Vermont Blueprint for Health is a statewide public-private initiative to transform care delivery, improve health outcomes, and enable everyone in the state to receive seamless, well-coordinated care.**
**KEY INNOVATION** **Having community health teams work with primary care providers to assess patients' needs, coordinate community-based support services, and provide multidisciplinary care for a general population. A web-based central health registry will capture all patient data.**
**COST SAVINGS** **A recent analysis of the first pilot program found significant year-over-year decreases in hospital admissions and emergency department visits, and their related per person per month costs. Further savings are forecast once comprehensive financial reform is in place. When rolled out statewide, the initiative is projected to save 28.7 percent in incremental health spending in the state by its fifth year.**
**QUALITY IMPROVEMENT RESULTS** **A qualitative assessment of pilot sites suggests that providers and patients value the role of community health teams in connecting patients with behavioral health, chronic care management, and social services support. Objective assessments suggest early improvements in clinical quality and use, such as better control of hypertension.**
**CHALLENGES** **For the initiative to be financially successful, there must be a measurable reduction in avoidable emergency department visits and hospitalizations. Insurers must shift spending away from remote call centers, disease management, and mailings, and into support for community health teams.**

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Vermont is in the vanguard of states reforming the delivery and funding of health care. With the passage of Vermont's Health Care Affordability Act in 2006 and subsequent health care–related legislation, the state is moving to provide all Vermonters with access to high-quality, affordable care. Universal coverage is in progress, largely through expanded access to Medicaid along with subsidized coverage for low-income citizens. Vermont is also one of eight states chosen for the Centers for Medicare and Medicaid Services' (CMS's) patient-centered medical home demonstration project, known as the Multi-Payer Advanced Primary Care Practice Demonstration.[1]

The Vermont Blueprint for Health, launched in 2006, is an integral part of the state's participation in the CMS project. Based on a foundation of medical homes supported by community health teams, it aims to deliver comprehensive, well-coordinated care to the general population

**A community health team** conducts a meeting in St. Johnsbury Hospital in Vermont. In the Vermont Blueprint for Health model, community health teams create a crucial link between primary care and community-based prevention of chronic disease. They offer individual care coordination, health and wellness coaching, and behavioral health counseling, and they connect patients to social and economic support services.

and improve health outcomes while controlling costs. All citizens in the state will be able to participate, without having to make copayments, obtain prior authorizations, or meet eligibility criteria. "It started as a chronic care initiative to make the Chronic Care Model [developed by Ed Wagner][2] come alive across the state," says Craig Jones, the Blueprint's director. "But it has evolved into a true transformation of the delivery system. This is really a new approach, where we're going to have broad, multidisciplinary care support for the general population, not just a targeted population."

The Blueprint calls for advanced primary care practices to serve as medical homes for the patients they serve, with comprehensive support from community health teams and an integrated information technology infrastructure. Each community health team is staffed by five full-time-equivalent employees and serves a population of approximately 20,000. The composition of any particular community health team is determined locally, with input from area practices and hospitals, but teams typically include nurse coordinators, behavioral health counselors, and social workers.

The initiative is now operating in three pilot sites and serves 60,000 people, or about 10 percent of Vermont's population: the St. Johnsbury Hospital service area, launched July 2008; the Burlington Hospital service area, launched October 2008; and the Barre Hospital service area, launched January 2010.

With the recent enactment of enabling legislation, Vermont is shifting from pilot to full program, and statewide expansion of the Blueprint model is under way. Operations have started in the Bennington area and will soon start in the Mt. Ascutney/Windsor area. The authorizing statute calls for at least two practices in each service area by July 2011, with all willing providers able to participate in the program by October 2013.

Expansion planning in all service areas is supported by Evaluation Quality Improvement Program facilitators, a scoring team based at the University of Vermont, and several other organizations. Vermont Information Technology Leaders is developing the statewide health information exchange and helping providers achieve meaningful use of electronic records.[3] Covisint DocSite hosts the Blueprint's central registry and assists practices and community health teams with its use.[4] The Vermont Program for Quality in Healthcare and Fletcher Allen Health Care, which is affiliated with the University of Vermont, are part of a network that provides training across the state to assist primary care practices in adopting the patient-centered medical home model.

Proponents of the Blueprint say that lessons learned in Vermont will help inform national efforts to implement health care reform. Jones points out that the state's Democratic legislature and its Republican governor, Jim Douglas, together launched Vermont's efforts. "Vermont has been working on universal coverage for many years, as well as a number of quality improvement initiatives," Jones says. "There is a culture of working together across the state that is extraordinary and important, and a culture of wellness and prevention. These things together make Vermont a great laboratory for implementing health care reforms."

## Community Health Teams

Just as important to the Blueprint model as the patient-centered medical home is the use of community health teams, which provide a crucial link between primary care and community-based prevention of chronic disease. They offer individual care coordination, health and wellness coaching, and behavioral health counseling, and they connect patients to social and economic support services. In addition, they perform community outreach to support public health initiatives. The teams' role is to enhance patient care both directly and indirectly: through individual services performed on the patient's behalf and through their support of individual providers and practices.

Photo: Vermont Blueprint for Health

Each community health team is led by a registered nurse, who performs clinical duties and supervises the team. The team includes one or more additional registered nurses, who work within physician practices. Their primary duties are to track patients who are overdue for appointments or tests, manage short-term care for high-needs patients, check that patients are filling prescriptions and taking their medications appropriately, and following up with patients on their personal health management goals. The behavioral health counselor also works in primary care practices, helping providers identify patients with untreated depression or substance abuse, and intervening quickly when necessary. The fact that the counselors work in a familiar setting lessens the reluctance some patients have to seek mental health treatment.

Community health workers on the team help patients fill out insurance applications, follow treatment plans, manage stress, and work toward their personal wellness or disease-management goals. In some cases, community health workers accompany patients to appointments and help them find transportation or child care. Public health specialists coordinate efforts between the community health team and public health initiatives to reduce common health-risk behaviors, as well as contributing to large-scale preventive efforts. Dietitians work with patients who have diabetes and other patients who need nutrition education and support.

"The model places a big emphasis on better self-management," Jones says. "We've had good success with individuals and even families setting health goals regarding diet, exercise, and smoking cessation." At the same time, he says, the teams benefit providers, too. "Now they have go-to people for patients who [have or are at high risk for] depression or who need help getting social services," says Jones. "Solo providers, small practices, health centers—whether independent or hospital-affiliated—are all going to benefit, and their patients and their patients' families are all going to benefit from the support of the community health team."

Jones emphasizes that the communication and connections do not flow just one way, from the primary care practice outward. "The idea is to go in all directions," he says. "Say a person comes into a local district office for social support services or heating assistance. If the social services person finds out the person doesn't have a primary care practice or medical home, he or she has people to contact who can connect the person to a provider."

As the pilots mature and more are launched, Jones expects that the community health teams' impact will increase. "Our idea is that [the] core community health team, by working with practices and other service providers, will create a web of close connections that will expand outward to form a much bigger functional community health team. This model has a synergy and a scalability that's hard to measure but [that] we're already seeing come alive," Jones says.

## Funding In The Blueprint Model

Primary care practices taking part in the pilots continue to receive fee-for-service payments from insurers and Medicaid. In addition, they receive a per person per month payment based on their National Committee for Quality Assurance score against patient-centered medical home standards. A team based at the University of Vermont scores the practices at baseline and every six to twelve months and submits the scores to the National Committee for Quality Assurance for review and formal recognition. The payment that a practice can receive ranges from $1.20 to $2.39, and rises or falls $0.08 with each five-point change in score.

"Our insurers are still paying fee-for-service; we couldn't turn that off, even though there were people who wanted to," Jones says. The upside is that all insurers can participate; the downside is that the system "promotes volume, as we all know," he observes. "But with the enhanced payment, we are beginning to balance quality against volume, although we still have a long way to go."

Each community health team employs the equivalent of five full-time-equivalent staff members, at an annual cost of $350,000. The community health team is considered a core resource, and its cost is shared among Vermont's three major commercial insurers as well as Medicaid. "For the pilots, we're subsidizing Medicare," Jones says. "With the announcement of Medicare's becoming part of Vermont's Multi-Payer Advanced Primary Care Practice Demonstration pilot, we will truly have all payers involved when we roll it out statewide."

## Outcomes: Better Health, Patient And Provider Satisfaction

The Vermont Child Health Improvement Program performed a qualitative assessment of the Blueprint pilots in early 2010 and submitted its findings to the Vermont Department of Public Health on June 30, 2010. The positive impact that community health teams have had on practices and their patients was the most often cited advantage of the Blueprint initiative.

Patients with chronic conditions were being seen more frequently, according to focus-group

discussions. Those who had been seen once per year, on average, were now being seen up to four times annually. Providers also said that having a behavioral specialist on the community health team and working at the practice site made it more likely that patients referred for mental health services would actually obtain them.

Providers said that they felt they could respond to a range of patient needs—nonclinical as well as clinical—with the community health team's support. As physician Dana Kraus of St. Johnsbury Family Health puts it, "Having access to the community health team removes the fear of asking a patient the simple open-ended question, 'So, how are things?' If the patient breaks into tears or admits that things at home are chaotic, I do not feel that I need to solve all of their social woes then and there by myself. I have a whole team to help. I can have them see Betsy, our behavioral health provider, within the week, or have Erica, our chronic care coordinator nurse, come right in and help sort out which resources they need. It truly expands my ability to care for patients by helping to tear, take, or break down social barriers that interfere with medical care."

A recent analysis of utilization patterns and costs for the St. Johnsbury pilot—the first one, launched in July 2008—found significant decreases from one year to the next in hospital admissions and emergency department visits per 1,000 patients, and their related per person per month costs: Inpatient use and per person per month costs decreased 21 percent and 22 percent, respectively. Emergency department use declined 31 percent, and associated costs per person per month fell 36 percent. And overall use and costs per person per month dropped 8.9 percent and 11.6 percent, respectively.[5]

## Challenges

For the Blueprint initiative to be financially successful, says Jones, there must be a measurable reduction in avoidable emergency department visits and hospitalizations, and insurers must shift spending away from remote call centers, disease management, and mailings and into community health teams. "We're asking them to do this by year 3," he says. Comprehensive data integration, sound assessment methodologies, and ongoing support and improvement are also critical. "To really roll out and expand a community-based system of care like this, and see cost savings from it, there has to be real support," he notes. "We're working on building a primary care extension service and other infrastructure, and collaborating closely with the University of Vermont on analytics and ongoing quality improvements."

For now, Jones and state officials believe that a 10–15 percent reduction in hospital admissions is achievable. Building a guideline-based system of care delivery may also reduce excess use. As current projections stand, total health spending in the state, now at $320 million, is projected to rise by another $100 million within five years. When fully rolled out statewide, however, Vermont Blueprint for Health could save 28.7 percent of that increase—savings that could make the most skinflint of Vermont Yankees proud. ■

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## NOTES

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