# Case Studies *of* LEADING PRIMARY CARE PRACTICE FACILITATION PROGRAMS

## Program Snapshot: Vermont Blueprint's EQuIP Program

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# PROGRAM SNAPSHOT: VERMONT BLUEPRINT'S EQuIP PROGRAM

Vermont Blueprint's Expansion and Quality Improvement Program (EQuIP) provides facilitation or coaching to primary care practices throughout the State as one component of the Vermont Blueprint for Health, the State's broader health reform initiative. EQuIP's facilitators assist practices in becoming patient-centered medical homes (PCMHs) and implementing and using health information technology (IT) supports, among other activities.

| Vermont Blueprint's EQuIP | |
|---|---|
| Context | Statewide health care reform initiative |
| Administrative Home | State Medicaid agency |
| Objectives | Provide primary care practices with support for:<br>• PCMH transformation and recognition<br>• Electronic medical record (EMR) implementation<br>• Building quality improvement (QI) capacity<br>• Reaching other goals identified by practice |
| Funding Source | Line item in State budget based on cost savings from a Medicaid 1115 waiver negotiated with the Centers for Medicare & Medicaid Services (CMS) |
| Staffing Model | Staff, consultant, and loaned professionals |
| Location of Services | On site at practices |
| Schedule and Duration | Twice monthly visits to practices; facilitators are permanently assigned to practices |
| Program Size | 13 full-time equivalent (FTE) facilitators |
| Ratio of Facilitators to Practices | One facilitator to 8-10 practices |
| Eligible Practices | Any primary care practice in the State that applies to participate (eligible practices estimated at 200) |
| Training and Support | Facilitators participate in onsite, virtual, and send away training programs; also co-train with practices in selected topic areas |
| Other Components and Supports | Learning collaborative, care coordination and other staff support through community health teams (CHTs), health IT and data systems assistance, multipayer enhanced per-member per-month payment |

In this case study, we profile EQuIP in detail, covering the following topics: background and context of the program; administrative structure; funding sources; practice facilitation activities; hiring, training, and supervision of facilitators; and evaluating and assessing program quality. We conclude with lessons from EQuIP's experiences for others interested in implementing a similar facilitation program.

# Vermont Blueprint's EQuIP Program: A Practice Facilitation Program Supporting Statewide Health System Reform

The Vermont Blueprint's EQuIP practice facilitation program began in 2008. It has several goals: to support reduced costs, improved access, and improved health outcomes for residents of the State by supporting PCMH transformation in all primary care practices in Vermont.

The EQuIP program is part of the State Department of Health Access (the State's Medicaid authority) and is one element of Vermont Blueprint for Health, the State's health delivery reform initiative. The Blueprint is a multicomponent intervention that's implemented by the Vermont legislature to address rising health care costs. In addition to the EQuIP practice facilitation program, the Blueprint also supports practices through learning collaboratives, resources for enhanced self-management support, community health teams (CHTs) that provide care coordinators and other staff to practices, and multipayer payment reform. (For general information on the Blueprint, see Appendix B.)

The EQuIP program provides practice facilitators to primary care practices that enroll in the Blueprint to help them build capacity for continuous QI, gain recognition as a PCMH by the National Committee for Quality Assurance (NCQA), and incorporate CHTs into their practices. EQuIP facilitators also work with health IT specialists from the State's Regional Extension Center (REC) to further electronic medical record (EMR) implementation in Blueprint practices and support meaningful use of EMRs and other health IT.

Important lessons learned by the EQuIP program to date include the following:

- There is no ready workforce for facilitation. In most cases, programs need to build their own by investing heavily in training.
- Direct hiring and management of facilitators makes it easier to stay true to the intervention model. Hiring facilitators through subcontracts with external organizations can present challenges to maintaining fidelity.
- Including EMR consultants from the HITECH REC on facilitation teams intensifies the effectiveness of both the facilitator and the consultant, and helps both work together to support PCMH transformation at the practices.
- Practices that are late adopters need a different facilitation approach than early adopters.
- Facilitators are most useful when they can help a practice focus on PCMH transformation activities, and assist the practice in identifying its goals. The focus is long-term commitment to improving care rather than an intermittent goal by the practice on the NCQA recognition.

## I. Background of the EQuIP Practice Facilitation Program

Practice facilitation is one part of the Vermont Blueprint for Health, designed to transform the way health care and health services are delivered in the State. The ultimate goal is to lower health care costs and improve health outcomes while providing citizens with high quality, well-coordinated health services. The Blueprint supports practices with a range of resources—including facilitation, care coordination, CHTs, enhanced self-management support, a statewide patient registry, and enhanced

payment for practices that are recognized as PCMHs. The Blueprint is designed to introduce "'systemness' in a non-system" by organizing community systems of health within a context of independent providers, practices, organizations, and multiple insurers.

The facilitation program was created within the Blueprint initiative to help practices gain this recognition as PCMHs, build their capacity for continuous improvement, and integrate care coordination and the CHTs into their workflow. Vermont Blueprint offices direct the EQuIP program and assign facilitators to one of 14 health service areas.

Each facilitator supports 8 to 10 practices with visits twice a month and virtual support as needed in between visits. Facilitators are permanently attached to their practices and are intended to be a long-term QI resource for the practice. Participation in the Blueprint is voluntary, and any primary care practice in the State is eligible to participate and get support from EQuIP practice facilitators. Practices enroll in the program by applying to the Blueprint office.

As of spring 2012, the EQuIP program has 13 facilitators (approximately 9.5 FTEs) actively supporting 100 primary care practices in the State. To date, 85 practices have received PCMH recognition from NCQA. The program expects to be supporting up to 200 practices by the end of 2013; this represents 90 percent of the primary care practices in the State.

## II. Administrative Structure of the EQuIP Program

EQuIP is housed within Vermont Blueprint in the Department of Health Access (the State's Medicaid authority). Being part of the larger Blueprint initiative gives facilitators access to additional human resources, such as the health service area program managers, advisory groups on integrated services and health IT, and community health teams.

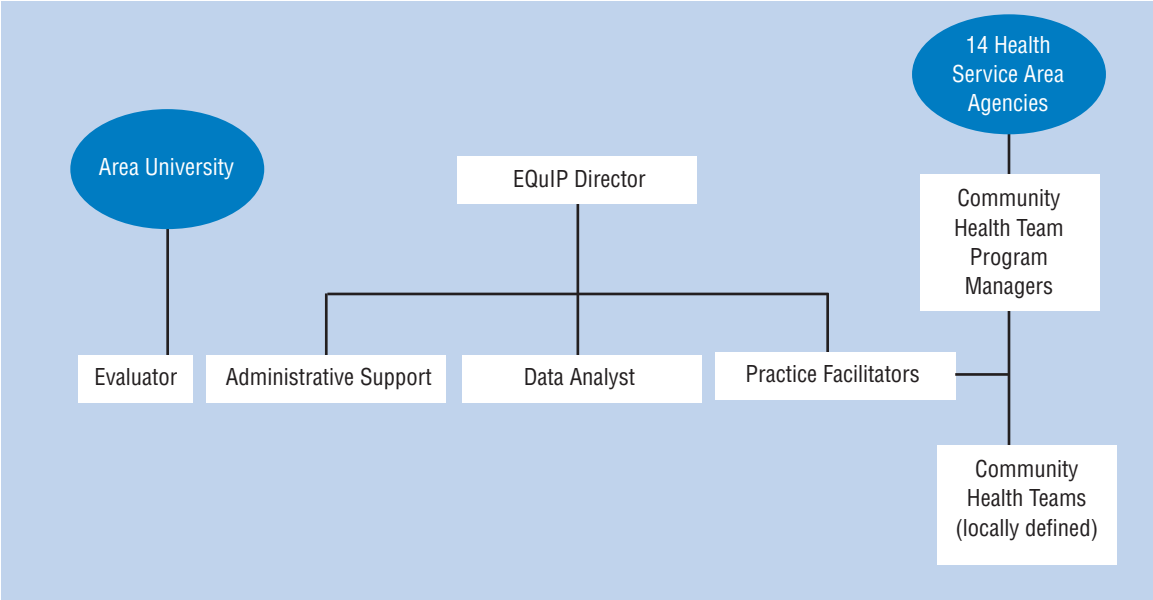
In addition to Blueprint resources, EQuIP facilitators leverage resources from other outside groups. Health IT experts from the State's Regional Extension Center for Health Information Technology work with the facilitators during EMR implementation and also assist the facilitators in helping practices meet PCMH recognition requirements. Staff that manage Covisint DocSite, the State patient registry, provide reports on patient demographics to the facilitators and the practices. The Vermont Child Health Improvement Program at the University of Vermont (UVM-VCHIP) provides content expertise in pediatric practices and QI in these settings to the program, as well as evaluators who specialize in completing PCMH recognition applications. The Bi-State Primary Care Association provides content expertise in working with Federally Qualified Health Centers and Rural Health Centers. Facilitators also have access to resources from the Vermont Department of Health's Division of Health Promotion, including resources for enhanced self-management support, data from its Center for Health Statistics on patient risk factors, and content expertise in chronic illnesses, such as asthma and diabetes.

The EQuIP program does not have its own advisory board, but consults with the various Blueprint advisory boards. See Appendix B for information on the Blueprint Advisory Boards.

**Staffing.** The program funds a part-time director who oversees 13 FTE practice facilitators and part-time administrative, data, and evaluation support staff (see Figure 1 for an organizational chart of

all staff; see Figure A.1 in Appendix A for a more detailed organizational chart with corresponding FTEs).[1] The data analyst tracks practices participating in the Blueprint. The evaluator created and now maintains a database that tracks the content of facilitator encounters with practices, as well as service hours provided, for internal QI and research purposes.

**Figure 1. Organizational Chart for Vermont Blueprint's EQuIP**




## III. Funding the Facilitation Program

**Funding source.** The EQuIP program is funded through Blueprint Vermont, a line item in the State budget funded through its Medicaid 1115 waiver. State legislators, the State Department of Health Access, and the director of Blueprint Vermont worked closely with CMS and the State legislature to design a sustainable funding model for the larger initiative. Vermont negotiated with CMS to keep any savings from its negotiated patient capitation rate and use them to reinvest in developing the Blueprint Vermont initiative, including the practice facilitation program.

**Program costs.** The program budget includes funding for all program staff, facilitator training, guest speakers with expertise in facilitation or specific content areas supported by the facilitators, attendance at conferences for ongoing professional development, travel to and from practice sites, and analysis and evaluation research on the program.

[1] EQuIP is part of the larger Blueprint initiative, which includes a director, three division directors, and two assistants. These individuals also provide some ancillary support to EQuIP.

## IV. EQuIP's Practice Facilitation Approach

All primary care practices in Vermont are eligible to participate in Vermont Blueprint and receive support from EQuIP facilitators. EQuIP's facilitation intervention is focused on seven areas (Table 1). Facilitation is just one component of the QI infrastructure, though; practices also receive other complementary supports.

**Table 1. Areas of Focus and Additional Quality Improvement Approaches Used in EQuIP**

| Seven Areas of Focus for the EQuIP Program | QI Approaches Used in Addition to Facilitation |
|---|---|
| Capacity for continuous QI | Learning collaborative |
| Elements of the PCMH | Health IT implementation support |
| Care coordination | Performance feedback from State patient registry |
| Community health teams | Enhanced per-member per-month payment from commercial and public insurers based on NCQA Physician Practice Connections-PCMH score |
| Enhanced self-management support | |
| EMR implementation that's aligned with the PCMH concept | |
| Use of patient registries for population management | |

### 1.Intensity and Form of Facilitators' Work with Practices

As part of the Blueprint, each practice must establish an internal, multidisciplinary QI team to work on continuous QI, integration of the CHT, care coordination, and NCQA's Physician Practice Connections-PCMH recognition. Care coordination consists of effective transitions for acute episodic care to preventive care planned visits, patient self-management support, decision support, and implementing and effectively using the health IT architecture. The teams include primary care providers, practice managers, nurses, office support staff, and a patient/consumer. One member of the team serves on the regional Integrated Health Services Workgroup. Each team is asked to provide summary information on the team, practice demographics, and PCMH application status to the Blueprint office. The teams meet at least monthly to review data and plan data-guided improvement.

Practice facilitators from EQuIP work with the practice improvement team and others weekly or biweekly, depending on practice need and preference, but at least once a month, to advance their transformation into PCMHs, build capacity for continuous QI, improve self-management support, and assist them in integrating CHTs into the practice.

Facilitators are assigned to support 8 to 10 practices engaged in active improvement at any one time, which currently allows the program to reach 125 practices. Additional facilitators will be added in the fall of 2012, increasing this reach to 225 primary care practices. The program aims to reach 200 practices, or 90 percent of the primary care practices in the State, by 2015.

Facilitators provide the majority of support on site at the practices. They use email, video conferencing, and telephone contact to provide additional support between visits. The schedule is tailored to each individual practice.

While PCMH recognition is a primary goal for the facilitation process, there is additional support for the practices in actually uploading and submitting their applications to NCQA. When practices have assembled materials and documentation for NCQA recognition process, the facilitator engages consultants from the Vermont Child Health Improvement Program who preliminarily score the practices based on the prepared materials and then scan and submit the application to NCQA. This decision was made to ensure that an objective third party that is an expert in standards completes the chart audit and verifies and reviews the materials.

Facilitators each work individually with their practices but may also use external consultants as needed, based on practice goals. In addition, they work regularly with consultants from the State REC when practices are establishing EMRs. The REC staff focus on the technology and its implementation in the practice. The facilitators make sure that the templates and workflow also support PCMH recognition and the principles of patient-centered care. They also collaborate with the manager of the State registry program, Covisint DocSite, to obtain reports on practice demographics and help practices use the registry data for QI and population management.

In an effort to formalize the collaboration between the EQuIP facilitators and both REC and State registry personnel, EQuIP is now piloting a "SWAT team" approach to facilitation related to IT integration. In this model, the practice facilitator, REC consultant, and registry manager will meet together on site with a practice when it begins with the Blueprint to assess the practice and develop a QI and EMR implementation plan. The team will continue to coordinate its work through monthly calls and onsite team meetings as needed, based on practice goals.

## 2. The EQuIP Facilitation Process

**First meeting.** During this meeting, the facilitator determines whether the practice is interested in focusing first on EMR implementation or on PCMH transformation and recognition. Based on this, the facilitator then either engages the health IT consultant from the State REC and connects that person to the practice, or initiates the PCMH transformation and recognition intervention with the practice.

**Initial goal setting and early win projects.** The facilitator works with the practice to help identify the first changes practice staff would like to make to improve patient care and outcomes. As the staff identify their improvement goals, the facilitator helps them connect these goals to PCMH principles and recognition requirements. Facilitators focus on achieving easy, early wins with their practices as an opportunity to begin building the practice's capacity for continuous QI and understanding of the principles of the PCMH and the requirements of NCQA's PCMH recognition process.

**Assessment.** Based on the goals the practice identifies in the first meeting, the facilitator selects the appropriate assessment. If the practice chooses implementing EMRs first, the REC consultant will work with the practice to conduct pre-health IT implementation. If the practice opts to work on PCMH transformation, the facilitator uses a comprehensive assessment tool, such as the one developed by Clinical Microsystems. The goal of this first assessment is to identify practice strengths and needs and obtain data that guide the practice's transformation plan.

Feedback on health service gaps at the practice. As the facilitator works with the practice and learns about the gaps in services experienced by its patients and the resources necessary to serve as a PCMH, the facilitator will give continuous feedback to the project manager in charge of forming the CHTs for the local area.

**Goal setting.** After the initial "early win" project, the facilitator continues to work with the practice to refine improvement goals and encourages staff to use a data-driven method for determining goals. The facilitator works with the practice to identify up to three high-priority conditions among its patients and three preventive health services to serve as the focus for the initial facilitation intervention. The facilitator works with the practice to use patient data and demographics to identify these conditions. These priority conditions then can serve as the priority conditions for the practice's application for PCMH recognition.

**Build organizational capacity for QI in the practice.** The facilitator helps the practice form a QI team if it doesn't have one. The facilitator also provides training to the team on the model for improvement and rapid-cycle change processes, and helps the team develop an improvement plan based on the results of the initial assessment conducted by the facilitator and recommendations of the team members. The facilitator helps the practice connect its improvement goals to the PCMH and its recognition process, and trains the team on both.

**Active improvement work and preparation for PCMH recognition.** Once the practice has defined its goals and developed an improvement plan, the facilitator provides a variety of supports to the QI team and practice to carry out the improvements. This support includes training on specialized content areas, workflow mapping and redesign, bringing in experts such as the health IT consultant from the State REC, gathering performance data to track progress toward improvement goals, and coordinating with a third-party vendor to conduct an initial PCMH scoring and prepare the application for submission to NCQA for PCMH recognition.

**Implementing the Community Health Team.** The facilitator works with the practice to redesign workflow and health IT systems to support implementation of the CHT within the practice. Currently the teams are placed in practices at the time of PCMH recognition, but will soon move to an approach in which they are placed in practices 6 months prior to submitting their application for recognition as a means of helping them meet NCQA's requirements and, more importantly, to address critical gaps in care identified by the practice.

**Submission of the Patient-Centered Medical Home application.** The facilitator coordinates with the practice and an outside vendor to prepare the practice's application to NCQA.

**Holding the gains and continuous improvement.** The facilitator continues to work on goals after the practice submits its application and remains available to the practice on a permanent basis to help with other improvement activities. Once a practice attains PCMH recognition, it must maintain this and reapply every 3 years. The facilitators remain available to support maintenance of the practice's status and preparation for reapplication.

## V. Hiring Practice Facilitators

**Core Competencies for the Blueprint Vermont Practice Facilitators.** EQuIP adopted existing core competencies for practice facilitators from the Quality Improvement and Innovation Partnership (QIIP) for its facilitators (QIIP 2010). Based on QIIP's work, EQuIP identified seven roles for practice facilitators and 21core competencies needed to fulfill these roles (Table 2).

### Table 2. Roles and Core Competencies of EQuIP Facilitators

| Roles | Core Competencies |
|---|---|
| • QI expert<br>• Communicator<br>• Collaborator<br>• Systems thinker<br>• Manager<br>• Educator and scholar<br>• Leader | • Function effectively as collaborative external consultants, integrating all of the facilitator roles to coach and facilitate ethical and team-centered QI integration and application<br>• Establish and maintain QI knowledge, skills, and concepts appropriate to their practice<br>• Perform a complete and appropriate assessment of a team, system of care, data, and outcomes<br>• Use coaching and facilitation skills effectively in the application of change theory<br>• Demonstrate proficient and appropriate use of QI methodology tools<br>• Seek appropriate consultation from other health or QI professionals, recognizing the limits of their expertise<br>• Develop rapport, trust, and ethical relationships with QI colleagues and primary health care teams<br>• Elicit and synthesize relevant information and perspectives of colleagues and teams<br>• Convey relevant nonjudgmental information to colleagues and teams, both oral and written<br>• Develop a common understanding<br>• Participate effectively and appropriately in an external consultative coaching role with primary care practices<br>• Effectively work with individuals to identify, mitigate, negotiate, and resolve conflict<br>• Identify the complex systems that represent the health care system<br>• Demonstrate the integration and application of knowledge of complex health care systems into QI coaching<br>• Demonstrate the use of coordinated self-management, information management, and resource management to provide consultative coaching effectively<br>• Maintain and enhance professional activities through ongoing learning<br>• Critically evaluate information and its sources, and apply this appropriately to coaching and facilitation of QI methodology content with teams<br>• Facilitate the learning of teams, colleagues, and others as a mentor and educator<br>• Contribute to the creation, dissemination, application, and integration of new QI knowledge, leading to its translation to practice, research, publication, and presentation<br>• Demonstrate a personal, professional commitment to excellence in consultative coaching<br>• Act as an ambassador for QI value to internal and external stakeholders |

Adapted from: Quality Improvement and Innovation Partnership. "Quality Improvement Coach Competencies." January 2010

**Hiring criteria and approach.** The EQuIP program director aims to hire individuals with excellent interpersonal skills and a 'sparkle' factor—meaning facilitators who are highly skilled in engaging individuals in difficult tasks and motivating them in their completion. Most of the facilitators have master's degrees; a bachelor's-level degree is considered a minimum requirement. Facilitators also must have several years of prior work experience. While it is preferable that this be in health care and QI, this is not required.

**Interview process.** EQuIP uses an experiential interviewing process for identifying facilitators. In addition to standard interview questions, applicants are given "tasks" to complete. These include preparing a presentation on the PCMH and delivering it to the EQuIP leadership and facilitation team, and engaging in an unexpected problem-solving activity during the interview, in which the applicant is handed an unfamiliar piece of equipment such as a smart phone and is asked to accomplish a specified task using the item. The interview team observes their approach to solving this problem and evaluates the degree to which the applicant's approach reflects core competencies needed for effective facilitation.

## VI. Training and Supervising Practice Facilitators

Training is an essential part of the program. The EQuIP Training program is called the Learning Health System, and consists of several components: onsite, virtual, send-away, and co-training. The training program leverages resources from across the Blueprint and with other facilitation programs.

The training program has evolved through several stages. Without a ready workforce of experienced facilitators, EQuIP invested heavily in training resources for its facilitators. At start-up, the program provided intensive training for its facilitators by bringing in experts from across the country and sending a portion of their facilitators to offsite programs, such as HealthTeamWorks and Clinical Microsystems.

All facilitators currently participate in a 4-week orientation training for EQuIP that provides an orientation to the Blueprint, training in the Model for Improvement and Clinical Microsystems, training in self-management support in primary care, and PCMH recognition through NCQA. This training takes place on site at the EQuIP central office.

After the initial workforce was created and new hires were added to the program, EQuIP began relying heavily on send-away programs to provide initial training. In addition, it established a mentorship program to help new hires integrate into the existing facilitation workforce. Each new hire is assigned an experienced facilitator as a mentor. They are asked to sit together at biweekly training sessions, and the new hire completes a 1-month field experience in shadowing his or her mentor in practices. New hires meet regularly with their mentors, who assist them in both skill development and building comfort with the program and the existing facilitators.

EQuIP stresses field experience in training as well as continuous training for its facilitators. All facilitators participate in weekly phone-based trainings and supervision calls, and in-person learning sessions twice a month. Facilitators also can take part in quarterly or ad-hoc learning collaboratives offered to practices as part of the Blueprint initiative. One or two facilitators are sent to conferences on special topics important to their work, such as asthma QI, self-management support, or QI methods, and then return to train the remaining staff.

In addition, EQuIP has developed an innovative co-training program, in which facilitators and practices train together in a topic area. The program co-trains facilitators and their practices on core content as a means of building skills and sharing good ideas and emerging best practices from the field with each other. This helps the facilitators and the practice build a shared vocabulary and vision of change. The practice works on the clinical content—for example, asthma guidelines—and the

facilitator attends to the process elements, such as workflow implications and health IT changes, to support the new clinical approaches.

The EQuIP program director gives supervision support to facilitators biweekly through a combination of phone conferences and onsite group sessions. During the one-on-one supervision sessions, facilitators review their progress with each of their practices based on their entries in the facilitators' practice registries.[2] They present case studies during group session, and the supervisor and facilitators provide feedback and perspectives from their own experiences.

## VII. Monitoring the Quality of the Program

The EQuIP program carries out both internal QI activities and external evaluations of its effectiveness.

*Internal assessment and QI processes for EQuIP.* EQuIP staff use a database developed by University of Vermont faculty specifically to gather quantitative and qualitative information on facilitator work on a weekly and monthly basis. The database captures information on time spent with practices, what the facilitators did during their encounters with practices, who participated in meetings with the facilitator, and the expected versus actual content and outcomes of the meetings. With support from the data analyst in the Blueprint Vermont office, EQuIP is also able to track the use and effectiveness of practice management and panel management databases in each practice, as well as the numbers and timelines of practices seeking and achieving PCMH recognition, and their levels. Table 3 provides the list of internal quality metrics used by EQuIP staff.

Program leadership uses these internal quality metrics to monitor progress toward the program's goal of supporting PCMH transformation in 80 percent of primary care practices in the State and fidelity to the facilitator intervention model. The leadership uses these data to identify areas of improvement for the program and guide training and supervision for the facilitators. Right now these QI activities are somewhat informal, but the program is moving toward a more structured internal QI approach that mirrors the methods its facilitators help introduce in their practices.

### Table 3. Internal Quality Metrics Monitored by EQuIP Leadership

| |
|---|
| Number of hours of support provided by facilitators to a practice |
| The content and activities during these service hours |
| Practice progress toward PCMH recognition |
| Practice progress toward implementing care coordination and self-management support |
| Use and effectiveness of practice management databases at each site |
| The number of practices that have achieved recognition, and at what level |

*External evaluation.* The EQuIP program partners with researchers at area universities to carry out evaluations of the facilitator program's outcomes, along with those of the larger Vermont Blueprint initiative. The researchers dedicate a minimum of 0.25 FTE to the evaluation as part of funded research by the Federal Government and are addressing questions designed to advance knowledge

[2] The practice registry is a Web-based tool that tracks practice progress toward program goals. The registry was developed and is maintained by a faculty member at the University of Vermont's Department of Family Medicine.

about the effectiveness of practice facilitation overall, and understand the optimal amount of facilitator support needed for practice change. Researchers also are looking at the impact of the Blueprint more broadly, on utilization, costs, and patient outcomes.

## VIII. LESSONS LEARNED

A number of lessons have emerged from the EQuIP program to date:

**A ready workforce for facilitation does not exist. In most instances, you'll need to invest heavily in training.** Initially, the EQuIP program had problems finding people with the necessary background to staff their program. To solve this problem, EQuIP invested heavily in training programs and built its own workforce from the ground up.

**Direct hiring and management of facilitators makes it easier to stay true to the intervention model. Subcontracting services out to external organizations can produce challenges to fidelity.** EQuIP originally staffed its program by subcontracting with external health care organizations for a percentage of a staff person's time to serve as facilitators. This made it hard for the EQuIP director to supervise or train the staff and oversee their work. Moreover the staff's ability to provide the contracted services often was compromised by competing demands from their home organization. As a result, EQuIP shifted to direct hiring of facilitation staff, and this has been much more successful. With this approach, staff loyalties lie with the EQuIP program, not another organization; EQuIP is able to supervise and monitor the progress of these staff effectively; and staff are not at risk of being pulled from their work as QI facilitators to address other needs in the health care organizations they're supporting.

**Practices that are late adopters need a different facilitation approach than early adopters.** Late-adopter practices are more skeptical about the potential benefits of QI work for their organizations and need more grassroots engagement approaches, in which the practice sets the goals and agenda for change. Early adopters, on the other hand, already have had an opportunity to see the improvement work's value.

**Using facilitators to complete NCQA PCMH applications can divert them from real improvement work into paperwork support.** When facilitators help practices complete their NCQA applications, it can easily shift the focus away from real practice improvement and transformation, in favor of filling out forms and collecting data for the PCMH application. It can be useful to have an outside person oversee submission of the application, so that the facilitator can stay focused on the improvement work needed to achieve certain levels of recognition.

**Including EMR consultants from the HI TECH RECs on facilitation teams intensifies the effectiveness of both the facilitator and EMR consultant and helps both work in a coordinated fashion to support practices' PCMH transformation.** EQuIP works closely with the State REC in improving care in State practices. Facilitators and the REC staff need to meet jointly with a practice at kick-off, and then periodically throughout the intervention, to coordinate work and realize synergies.

This case study was prepared by Lyndee Knox, LA Net, and Erin Fries Taylor, Mathematica Policy Research.

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## Resources

Blueprint Vermont Implementation Manual. hcr.vermont.gov/sites/hcr/files/printforhealthimplementationmanual2010-11-17.pdf

General Information on Blueprint Vermont hcr.vermont.gov/blueprint

Quality Improvement and Innovation Partnership. "Quality Improvement Coach Competencies." January 2010. qiip.ca/user_files/QIIP%20-%20QI%20Coach%20Competencies%20Launch%20Jan-10.pdf

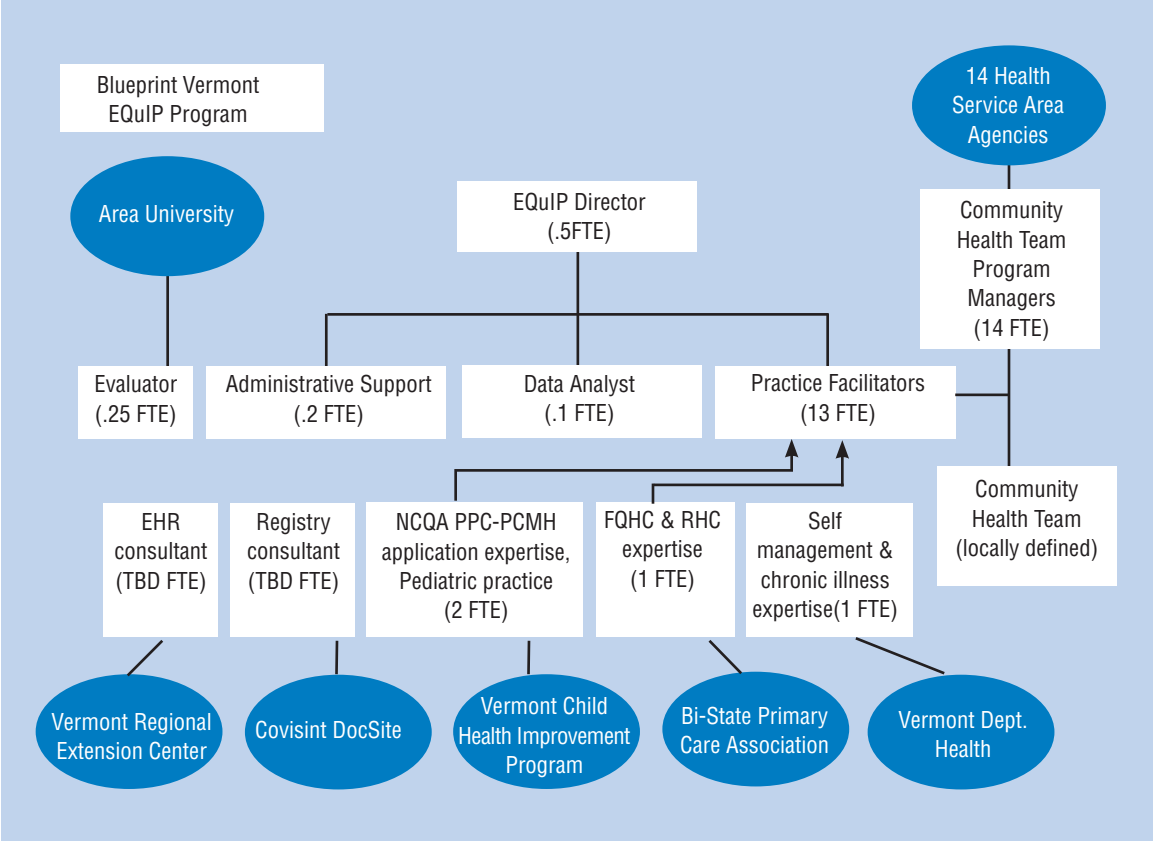
## Related Literature

Bielaszka-DuVernay C. Vermont's Blueprint for medical homes, community health teams, and better health at lower costs. Health Aff 2011;30(3):383-6.

Hsaio WC, Knight AG, Kappel S, and Done N. What other States can learn from Vermont's bold experiment: embracing a single payer health care financing system. Health Aff 2011;30(7):1232-41.

# Appendix A

**Figure A.1. Detailed Organizational Chart for Vermont Blueprint's EQuIP**



# APPENDIX B

**The Vermont Blueprint for Health.** The Vermont Blueprint for Health is a State-led initiative designed to transform the way that health care and health services are delivered in Vermont. The overarching goal of the Blueprint model is to provide citizens with high-quality, well-coordinated health services. Its focus is to implement a health care model that organizes community systems of health within a context of independent providers, practices, organizations, and multiple insurers. It is described as "working to establish 'system-ness' in a non-system." A central component of the Blueprint is changing the way in which health care is paid for, moving away from a fee-for-service model that rewards volume over quality, to one that incentivizes quality services that meet the needs of individuals and communities.

The Blueprint also provides support to practices for transformation to PCMHs, resources for enhanced self-management support, health IT, evaluation, learning health systems activities, multi-payer payment reforms and CHTs developed to provide care coordinators to practices and fill gaps in care.

The CHTs, which are funded through multipayer financing reforms, serve a group of practices across each of the 14 health service areas of the State. Rather than use a top-down approach, these teams are locally determined. The health and human services providers in each area work together to identify service gaps and form the appropriate CHT to address these gaps.

Vermont Blueprint is housed in the State's Department of Health Access, which oversees Medicaid for the State. The Department is headed by a long-time advocate of both the Blueprint and the practice facilitation program.

The Vermont Blueprint grew out of support by executive government, legislators, and health care leaders in the State. A cost model showing the return on investment associated with improvements in quality developed by a health economist from the State has been instrumental in building support for the Blueprint.

**Advisory boards.** The Blueprint is advised by four advisory groups. The Executive Committee oversees general operations of the Blueprint. The Expansion Design and Evaluation Committee advises the Blueprint director on overall program design, evaluation, and statewide expansion. The Payment Implementation Work Group advises the program on implementation of payment reform, and the Provider Practice Advisory Group advises the director's office on provider experience with Blueprint participation and clinical guideline adoption.

**Administrative organizations.** Each health service area in Vermont must identify, through consensus, an administrative organization that will lead implementation of the Blueprint in each service area and receive money for hiring the Community Heath Teams. These organizations usually are hospitals or, in some instances, Federally Qualified Health Centers or physician hospital organizations. Each administrative organization must hire a program manager for the Blueprint for its area. This individual coordinates meetings of the local workgroups, recruitment of area practices, implementation of community based self-management, and hiring and management of the community health teams for their service area.

**Integrated Health Services Workgroup.** Each health service area also forms an Integrated Health Services (IHS) Workgroup. The IHS Workgroup is responsible for planning the community health team's composition, strategies for coordinated health services, and logistics for scoring practices on NCQA's Physician Practice Connections-PCMH standards.

**Health Information Technology Workgroup.** Each health service area also forms a health IT workgroup. This workgroup provides a forum for health care leaders from each primary care practice participating in the Blueprint to interact with the REC staff and manager of the State registry on EMR and registry implementation planning and use, and to connect to the State Health Information Exchange.

**CHTs.** Early on in the development of the Blueprint, the legislators and payer groups engaged in data-driven decisionmaking about first steps for improving care in Vermont. At the time, the majority of the payer groups in the State were mandating telephonically based chronic care programs. Data on the effectiveness of these programs were presented to the legislature and contrasted to the better outcomes achieved from person-based programs. Two payers bought into the concept of improved outcomes from person-based support, and the CHTs were born. Later, the State legislature mandated all major commercial insurers in the State share the cost of the CHTs.

The CHTs are a key component of the Blueprint. They are multidisciplinary teams hired and managed through the 14 Health Service Area agencies to provide seamless patient care throughout the community. The administrative entity for the CHTs is located in the health service area and is often a hospital. Two are Federally Qualified Health Centers, and one is a physician's association.

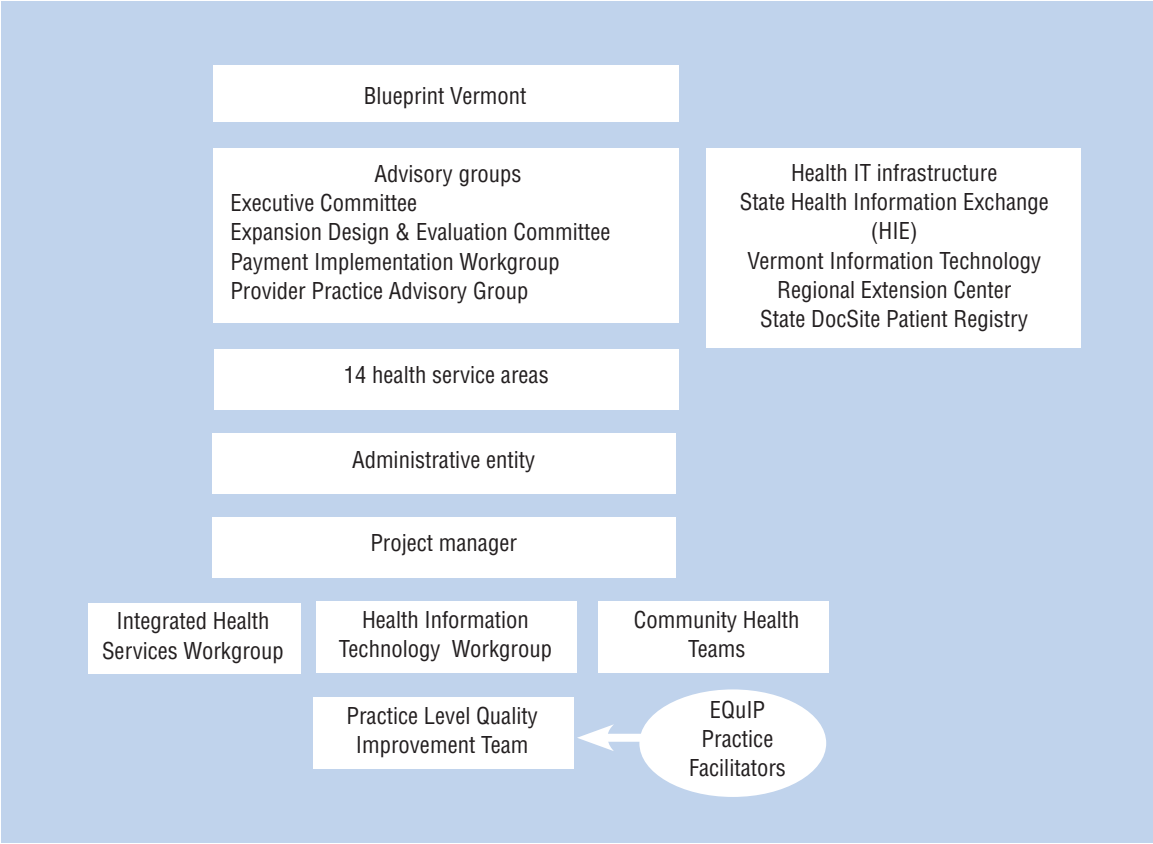
The CHTs are administratively housed in these organizations and coordinated by the Health Service Area project manager. The project manager is responsible for convening local stakeholders to identify gaps in health services that will be remedied by the health teams, incorporating feedback from local practices about service gaps into the formation of the team, coordinating work of the team within health care settings, and collaborating with the EQuIP program and its facilitators in implementing the team in individual practice sites.

The teams are funded at $35,000 for every 2,000 patients. Each team then decides how to use these resources to fill gaps in services and reorganize services in its area so they are more effective and efficient. The team considers what services need to be embedded in area primary care practices, such as a nurse care coordinator. These resources then are embedded at the practice sites and shared across practices, depending on patient volume. The makeup of these teams is driven by local needs.

Most teams include nurse care coordinators, social work care managers, and mental health providers who deliver short-term care. The team makeup is determined by the local practices and what they determine their needs to be; for example, many CHTs also provide education on asthma and diabetes management, receive support from dieticians, dentists, or licensed alcohol and drug counselors who can serve the needs of the general population, or may focus on moving higher acuity patients over to chronic care programs. Practices receive this support at the time of NCQA recognition. With the advent of the 2011 NCQA standards, it is likely that the insurers will agree to provide the CHT 6 months prior to submission to NCQA for recognition as a PCMH.

**Practice QI Teams.** As a participant in Blueprint Vermont, each practice is required to establish an internal, multidisciplinary QI team to work on continuous QI, NCQA's Physician Practice Connections-PCMH recognition, and integration of the CHT and care coordination. The latter includes effective transitions for acute episodic care to preventive care planned visits, patient self-management support, decision support, and implementation and effective utilization of the health IT architecture. Each team is asked to provide summary information on the team, practice demographics, and their PCMH application status to the Blueprint Vermont office. The teams are asked to meet no less than monthly to review data, plan data, and implement rapid cycle QI. The teams may include primary care providers, practice managers, nurses, office support staff, and a patient/consumer. One member of the team serves on the regional IHS Workgroup.

### Figure B.1. Team Structure of Vermont Blueprint for Health



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