

***VERMONT*2007**

Blueprint for Health Annual Report

Annual Report to the Legislature on **Act 191 2006 (ADJ) Session**
January, 2007



108 Cherry Street, PO Box 70
Burlington, VT 05402
<http://healthvermont.gov>

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Executive Summary

In accordance with *Act 191* this update on the implementation on of the Vermont Blueprint for Health Chronic Care Initiative (Blueprint) is submitted to the General Assembly. This report discusses the impact of chronic disease in Vermont and provides a general outline of how the Blueprint for Health is approaching these issues. It then focuses on the progress made in 2006, including the expansion of the Blueprint for Health into four additional Hospital Service Areas (HSAs), the growing number of participating providers, the addition of several chronic conditions to the care model, and the early development of a new statewide health data tracking network - the Chronic Care Information System. The Annual Report concludes by looking forward to 2007 and some of the goals that the Blueprint for Health aims to accomplish in the coming year.

The health care system is the most complex sector of the economy; and a population approach to system transformation of this magnitude requires a shared vision among key stakeholders. The Blueprint has engaged a diverse group of both public and private partners to create and execute a shared vision, affording Vermont the best opportunity for real sustainable change. The Blueprint is built on the premise that preventing disease and improving the quality of care for people with chronic illness are effective ways to reduce the overall demand for the highest-cost treatment services; leading, in time, to moderation in health care costs and improved quality of life. This update shows the steps taken in 2006 to reach this long-term goal in partnership with stakeholders at every level of the health care infrastructure.

This report, the Vermont Blueprint for Health Strategic Plan, and additional information about the Blueprint for Health is available at <http://healthvermont.gov>, then click on Legislative Reports.

Introduction

The Vermont Blueprint for Health Chronic Care Initiative was launched in 2003 by Governor James Douglas, and was endorsed by the Vermont General Assembly in 2006 under Act 191. The Blueprint is built on the premise that preventing disease and improving the quality of care for people with chronic illness are effective ways to reduce the overall demand for the highest cost treatment services; leading, in time, to moderation in health care costs; and most importantly, focusing on enhanced quality of life.

The Vermont Blueprint for Health articulates a clear vision: *Vermont will have a statewide system of care that improves the lives of individuals with or at risk for chronic conditions.*

To achieve this vision, the Blueprint will:

- Utilize the Chronic Care Model as the framework for system change (Figure 1);
- Utilize a public-private partnership to facilitate and assure sustainability of the new system of care; and
- Facilitate alignment of Blueprint priorities and projects with other statewide health care reform initiatives.

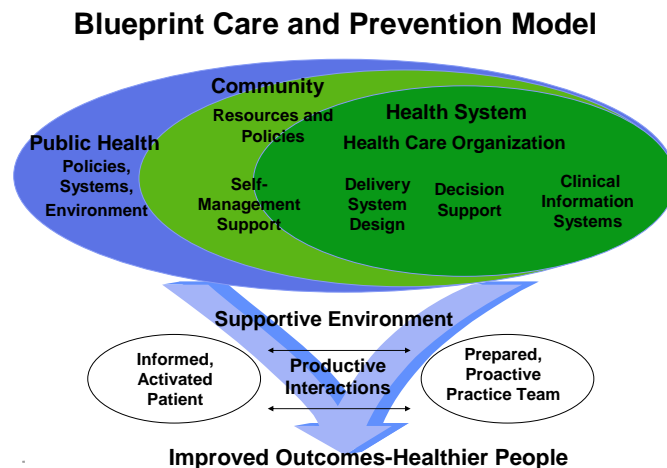


Figure 1: Adapted from the Chronic Care Model which is used by permission of “Effective Clinical Practice”. Original publication: Wagner, EH. *Chronic Disease Management: What will it take to improve care for chronic illness?* Effective Clinical Practice 1998;1:2-4.

Impact of Chronic Disease

Chronic conditions are the most serious and costly health problems facing Vermont today. Unless we act now, costs for treatment will rise, as will the number of individuals with chronic disease. The graph below poignantly demonstrates the projected mortality rates for diabetes. It shows that we can affect the future of our citizen's health if we act now to improve treatment and to prevent obesity, a precursor to most chronic diseases.

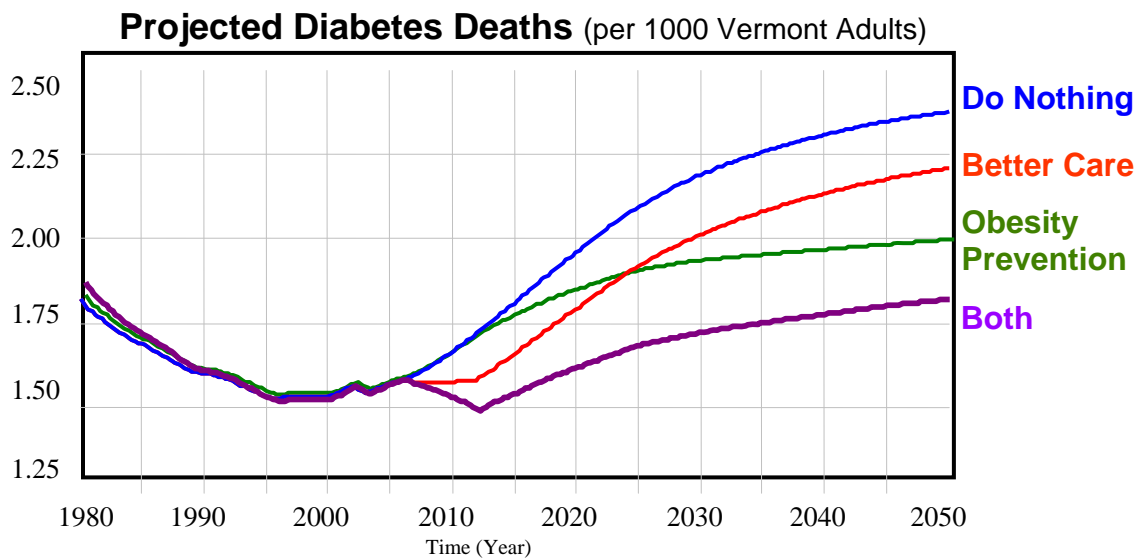


Figure 2 Vermont Department of Health and Centers for Disease Control. Diabetes Systems Modeling Project, 2005. (Unpublished)

“Unless effective population-level interventions to reduce obesity are developed, the steady rise in life expectancy observed in the modern era may soon come to an end and the youth of today may, on average, live less healthy and possibly even shorter lives than their parents.”¹

New England Journal of Medicine

¹ New England Journal of Medicine 352; 11 March 17 2005 pgs 1138-1145 Special Report: A Potential Decline in Life Expectancy in the “United States in the 21st Century. S. Jay Olshansky, PhD. Douglas J. Passaro, MD Ronald C. Hershow, MD. Jennifer Layden, Bruce A Carnes, PhD, Jacob Brody, MD, Leonard Hayflick, PhD, Robert N. Butler, MD, David B Allison, PhD, David S Ludwig, MD, PhD

Blueprint for Health Approach

The Blueprint for Health is a new approach to giving Vermonters the tools they need to manage their chronic care. It is proactive and holistic, rather than reactive and fragmented. It is designed to help people who have chronic conditions, and those who may be at risk for developing them, through prevention and planning. The Blueprint seeks to achieve its goals by establishing and promoting the following:

- **Public policies that support healthy lifestyles** and effective health care.
- **Effective and accessible community-centered programs and activities** to encourage and maintain healthier lifestyles.
- **Self-management tools for individual participation and empowerment**, through innovative programs such as the Healthier Living Workshop.
- **Improved health care information systems**, including the Blueprint's Chronic Care Information System (CCIS), to give physicians and other medical professionals the critical information needed to deliver evidence-based care.
- **Coordinated approaches by health system organizations** including insurers, state government, and non-profit health care organizations. This will result in better support for consumers and providers alike in the areas of patient education, quality standards, disease management, and incentives to deliver better care.

Vermont Prevention Model

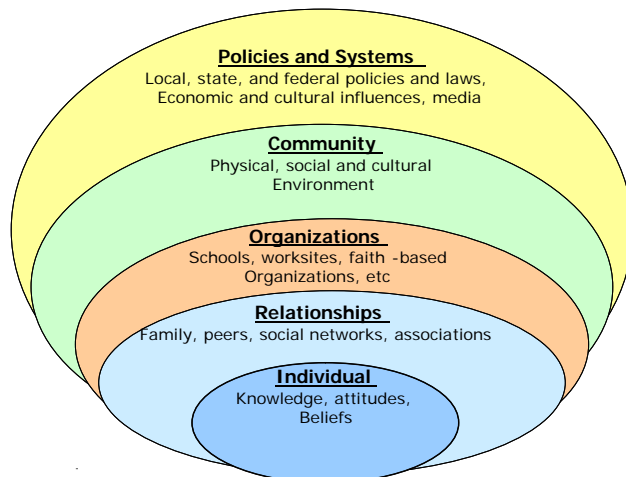


Figure 3: This figure shows Vermont's social ecological prevention model adapted from: McElroy KR, Bibeau D., Steckler, A., Glanz, K. *An ecological perspective on health promotion programs*. Health Education Quarterly.

2006 Achievements

Increased Participation: Expansion to Six Hospital Service Areas

The Vermont Blueprint for Health first implemented its chronic care model in 2005 in two hospital service areas (HSA):

- Northeastern Regional Medical Center in St. Johnsbury
- Southwestern Medical Center in Bennington

In fiscal 2007, these two HSAs have expanded use of the chronic care model to include hypertension in addition to diabetes.

In 2006, four additional HSAs were selected through a competitive bidding process and funded:

- Mt. Ascutney Hospital in Windsor
- Springfield Hospital
- Central Vermont Hospital in Berlin
- Fletcher Allen Health Care in Burlington

Participating HSA's have been awarded funding to support regional project managers, self-management, community coordination and provider participation. The regional project managers oversee implementation, including provider recruitment, education and payment of provider stipends for participation; monitor outcomes; and provide regular reports on progress to the Vermont Department of Health.

Vermont Department of Health District Office staff support local assessment and development of physical activity programs in communities not yet fully funded by the Blueprint. Funding for self-management regional coordination has been awarded to four additional HSA's, to support local implementation.

The following map illustrates expansion of the Blueprint to date.

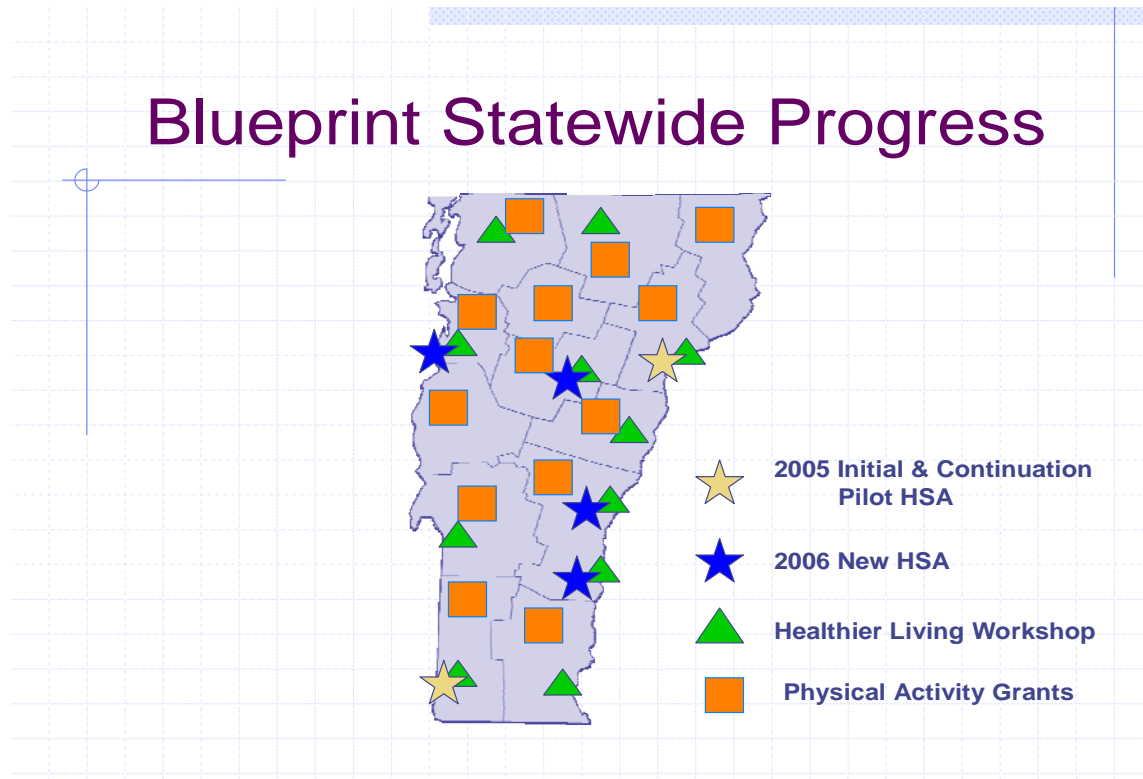


Figure 4: Statewide map of Blueprint implementation progress

More Communities Taking Action to Support Health

The Vermont Blueprint for Health encourages communities to become healthier places to live, work, learn and play. Collaboration among state and local programs has helped to better establish consistent program guidelines and coordinated efforts to support physical activity initiatives, and additional provider education.

In 2006, funding for physical activity promotion and chronic disease prevention activities has been provided through comprehensive Blueprint for Health grants to the six funded hospital service areas. Also, in preparation for expanding the Blueprint beyond the six HSAs, communities throughout the state have been awarded mini-grants to assess community infrastructure, develop coalitions and walking programs, and engage residents in these activities.

To support the communities in their work, the Department of Health has established Chronic Disease Public Health Specialists in five district offices around the state. The individuals in these new positions will assist communities in their work and assure integration with other Health Department chronic disease activities at the local level.

Finally, the Coordinated Healthy Activity, Motivation and Prevention Programs (CHAMPPS) initiative, created in 2006 in Act 215, established a program for awarding competitive, substantial, multi-year grants to comprehensive community health and wellness projects. CHAMPPS was designed to promote healthy behavior and disease prevention across the community and across the lifespan, and to form the foundation for community wellness initiatives at the Department of Health. Because of its direct relevance to the work of the Blueprint, CHAMPPS is being closely coordinated internally with the Blueprint community component. The staff leader for the Blueprint community component is also managing CHAMPPS implementation. CHAMPPS has improved internal collaboration among chronic disease programs and staff, which will ultimately serve the Blueprint through greater efficiency and programmatic expertise.

*“The challenge got us all thinking about exercise and taking better care of ourselves.”
“Getting out and walking, feeling good about it, walking more steps each day. Pulling together as a team. Great program.” “It motivated us to exercise more.” “It gave us a common bond other than our regular work duties, encouraging friendships and connections with others.”*

*Quotes from four of the nearly 1800 individuals who completed
the Bennington HSA **Trek for Health**, 2006*

Successful Healthier Living Self-Management Programs

Because Vermonters must take a central role in the management of their health, consumer participation is critical for the success of the Blueprint for Health. Early indications suggest that Vermonters attending the Healthier Living Workshop are using the skills learned in the workshop and the confidence they gained through participating, to take a central role in the management of their health. A sign of better self-management is that evaluation data from

participants, who completed the workshop, shows a decline in the number of physician and emergency department visits at 6 and 12 months post workshop completion. Over 300 people have completed this evidence-based program developed by Stanford University and adopted by the Blueprint. Currently there are over 80 trained workshop leaders in 10 hospital service areas throughout the state.

Healthier Living Workshop Participant Data

Frequency of MD and ED visits post training

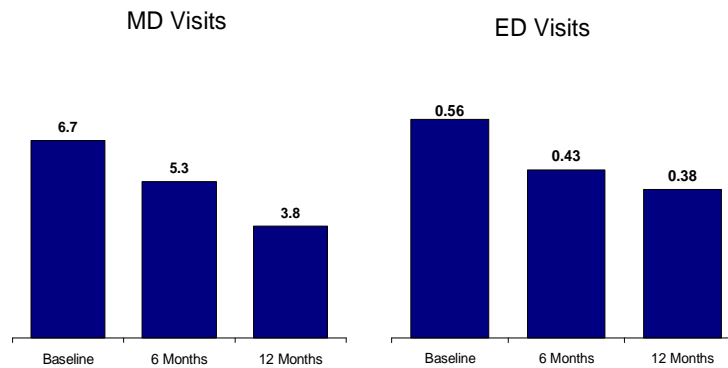


Figure 5: Healthier Living Workshop- participant survey results, at one year.

“The Healthier Living Workshop saved my life.”

Healthier Living Workshop Participant in Woodstock, VT

“Trying to cope with everyday situations is trying in itself. If you add the frustration, loneliness, and pressure of meeting everyday problems that may come about, not to mention any chronic problems we have, it can be overwhelming. That is the reason I jumped at the chance to take the Healthier Living Workshop. I thought it might just answer some of the problems, so I could handle them in a better way. At first it was hard to talk about personal information in front of a group, but as the class continued, they all had their problems also. I wasn't alone! The book was very helpful and informative. I found it filled me in on many questions I had in mind, and it will help me to complete some the projects I need answers for. I really enjoyed the course and the people I have met. My sincere thanks!”

Healthier Living Workshop participant in Danville, VT

Growing Provider Participation

In 2005 and 2006, over 200 physicians, nurse practitioners, and physician assistants (nearly 75 percent of all primary care providers from the six funded HSAs) began participating in the Blueprint for Health. With support of the Blueprint, these health care providers are active participants, learning about innovations and evidence-based standards for the delivery of effective, proactive care for patients with chronic conditions. They are receiving comprehensive education on proactive care management for their patients with chronic conditions, and incorporating innovative practice flow changes and evidence-based standards for the delivery of the best quality of care.

In 2007, the Blueprint will address two new chronic conditions, hypertension and hyperlipidemia. Supporting clinical guidelines are in final stages of adoption. These are in addition to diabetes, the first chronic condition the Blueprint focused on in Fiscal 2006.

The Blueprint Provider Practice Workgroup, a dedicated statewide coalition of health professionals, is assisting to facilitate adoption of these standards. This stakeholder group meets regularly and advises the Blueprint on clinical issues such as adoption of new evidence-based, best practice guidelines, metrics of success and monitoring of progress, as well as helping to address barriers to achievement of clinical goals.

“It is critically important for the provider community to change the way we care for individuals with chronic conditions. We must assure that we link what we do in the office setting with the resources available in the community, in order to best support our patients in effective management of their health. The Blueprint is helping providers and communities to activate these community links in order to improve the health of individuals with chronic conditions.”

Dr. John Brumsted, chief quality officer, Fletcher Allen Health Care, Burlington, VT

Patient Information Systems Development

The Vermont Department of Health, in partnership with Vermont Information Technology Leaders (VITL), has contracted with GE Health Care and Orion Systems to develop the new web-based chronic care patient information system. This Chronic Care Information System (CCIS) will enhance health care providers' ability to manage chronic illnesses for patients by giving providers the right information at the right time according to evidence-based clinical guidelines.

In 2007, Mt. Ascutney Hospital in Windsor will be the first participating HSA to install and test this system. The CCIS will be available to Vermont physicians free-of-charge. It is a web-based system, which means physicians do not need to purchase expensive systems to use it. They just need a computer with Internet access.

The privacy of patient data in the CCIS will be protected in a variety of ways:

- GE's data center uses secure databases and fire walls that meet all HIPAA security requirements.
- GE increases security by storing patient demographic data and patient medical data in separate databases.
- Providers and labs will connect to GE's data center with a secure Virtual Private Network (VPN) that encrypts all data before sending it across the network.
- Orion's software restricts access to patient data based on defined roles for users, such as physician, nurse, administrator, etc. CCIS users can only view the data for their own patients.
- Audit trails will reflect all user activities, including viewing and editing of patient data. Patients can get reports that show who has accessed their medical data.

Until the CCIS is operational, providers in continuation communities are using a web-based system called the Vermont Health Record, which is also provided by the Blueprint.

“As the science of medicine grows more complex, physician can no longer rely on just their memory and training. The Blueprint is helping doctors learn and develop systems we need to guarantee that each of our patients always gets the best care we know how to give them.”

Primary Care Physician, Internal Medicine, Bennington, VT.

Coordinated Public Policies

With passage of Act 191, the Vermont Legislature's support for the Blueprint for Health strengthened existing links between government and private partners. There is alignment of Blueprint priorities and projects with all other statewide health care reform initiatives.

In 2006, the State incorporated the priorities of the Blueprint for Health in the selection and contracting process when, as an employer, it chose a health insurance benefits provider for state employees.

Through the Blueprint, physicians are collaborating with the Office of Vermont Health Access (OVHA) to select and adopt common clinical guidelines required for implementation of both the Blueprint and OVHA disease management program. With input from insurance partners, it is anticipated that these guidelines will be adopted as common tools for assuring best clinical practice.

Another example of achievement in coordinated public policy is the work of Department of Health staff with the Agency of Transportation advisory committee to develop a five-year Vermont Pedestrian and Bicycle Policy Plan, and Vermont Transportation Agency staff participation on the Fit & Healthy Vermonters advisory committee and on the Blueprint for Health Community Workgroup.

Health System Collaboration

Effective collaboration with public and private insurance carriers, as well as support from private business and other organizations, is essential to the success of the Blueprint for Health.

The Blueprint has support and participation from Vermont's major insurance providers. The health plans of approximately two-thirds of all insured Vermonters participate in the Blueprint. This includes:

- Blue Cross and Blue Shield of Vermont

- MVP Health Plan
- Connecticut General Life Insurance Company
- Office of Vermont Health Access (Vermont Medicaid)

All carriers are participating on various Blueprint workgroups and several are also members of the Blueprint Executive Committee. Also, the Blueprint is working closely with the Office of Vermont Health Access to identify and adopt in 2007 a common set of evidence-based standards to support the Medicaid Disease Management program.

National Recognition

The Vermont Blueprint for Health is unique, and as a result continues to garner attention at the national level. Other states, as well as the federal government, are now looking at what Vermont is achieving through the Vermont Blueprint for Health. The Blueprint is sharing experience and information on best practices with national health policy partners such as Academy Health, a Washington, D.C. health policy organization.

In 2006, the U.S. Department of Health and Human Services Agency for Healthcare Research and Quality helped with sponsorship of a public event bringing national experts and local stakeholders together in Vermont. In addition, they have provided expertise on design and analysis of consumer and provider surveys.

National organizations requesting presentations or expressing interest in the Blueprint:

- Agency of Healthcare Research and Quality
- Association of State and Territorial Health Officials
- Center of Health Policy Planning and Research, University of New England
- Centers for Disease Control and Prevention
- National Association of Chronic Disease Directors
- Department of Health and Human Services Secretary's Prevention Summit
- Institute of Healthcare Improvement
- National Health Policy Academy
- Council of State Government

Provider and Consumer Survey

In October 2006, the Blueprint carried out the first annual provider and consumer satisfaction survey. The survey targeted the initial two Blueprint HSAs, Northeast Medical Center in St. Johnsbury and Southwestern Vermont Medical Center in Bennington. In addition to direct service providers and consumers, the Blueprint surveyed the practice managers in each participating medical practice. Extensive analysis is currently underway and final results will be available in Spring 2007.

Preliminary Response Results

Overall, about two-thirds of the 63 individual participating Blueprint providers in the two surveyed HSAs completed a survey; and a similar proportion of 24 participating practices returned a survey. In St. Johnsbury, 12 of 23 participating providers responded representing three of the four participating practices. In the Bennington HSA, 29 of 40 participating providers filled out a survey; representing 14 of 18 participating practices.

For the consumer satisfaction surveys, each pilot community was asked to identify and directly distribute 1,000 surveys to patients with diabetes in participating practices. As of mid-December, 536 surveys have been tabulated with additional responses still coming in. Of the 536 surveys tabulated, 231 were from patients in St. Johnsbury and 305 were from Bennington patients.

	Providers (MD/PA/NPs)		Practices		Patients	
	# of Participating Providers	Total Responses	# of Participating Practices	Total Responses	# of Surveys Sent	Total Responses
St. Johnsbury	23	12	6	3	1000	231
Bennington	40	29	18	14	1000	305
Total	63	41	24	17	2000	536

Figure 6: Survey results from initial pilot communities.

Preliminary Results: Consumer Satisfaction

The Consumer Satisfaction Survey shows promising preliminary results. While data from survey responses are still being processed, early analysis shows that many patients participating in the Blueprint are confident about managing their chronic conditions and are prepared to take responsibility for their health. The initial results also point to some potential disconnects between patients and providers. For example, many providers indicate that they have recommended physical activity and nutrition consultation to their patients, but fewer than half of the patients recall those recommendations. Communication between provider and patient, including the potential for written communication, will need to be a future area of focus.

Preliminary Results: Provider Education and Training

Health care providers indicate a number of different motivations for joining the Blueprint; however, the primary motivations are to improve care for their patients and to improve the efficiency of their practices.

The most widely attended training was the Blueprint Chronic Care Model training. At least half of the providers also attended training on clinical microsystems and rapid cycle change techniques (Plan-Do-Study-Act). While it is too early to report on measures with statistical confidence, it is interesting to note that providers who attend training on patient self-management are two times more likely to recommend self-management workshops to their patients than providers who did not attend the self-management training session.

The Blueprint has instituted a goal of provider practice attendance at 80 percent of local Blueprint training sessions for communities funded in fiscal 2007.

Blueprint Expenditures

The legislature awarded the Blueprint \$5.3 million in funding in fiscal year 2007.

Communities

Over one million in funding goes directly to Blueprint for Health communities for implementation efforts including project management staff, provider participation and training support, community programming and consumer services.

In FY2007, as the result of a competitive bid process, four new hospital service areas were funded: Central Vermont Hospital in Berlin, Fletcher Allen Health Care in Burlington, Springfield Hospital, and Mt Ascutney Hospital in Windsor. The addition of these communities, together with the original HSAs, Northeastern Regional Medical Center in St. Johnsbury and Southwestern Medical Center in Bennington, significantly expanded the scope of the Blueprint and as a result, an estimated 50 percent of providers statewide and their diabetic patients are participating in the Blueprint.

To support communities to initiate and sustain changes required for delivery of evidence based care, the Blueprint also covers the cost of provider and office staff education, coaching and financial stipends which are administered by local project managers to help offset the cost of participation and/or to reward achievement of process and clinical outcomes.

Information Technology

In addition to direct funding to communities, the Blueprint is also supporting the health information technology infrastructure required for both individual and population-based care. Nearly \$3.5 million of fiscal 2007 funds are allocated to information technology requirements which includes some one time costs; and working collaboratively with Vermont Information Technology Leaders (VITL) and health information technology vendors (GE Healthcare and Orion Health) on development of the Chronic Care Information System (CCIS).

The graph below depicts the current year's operating budget, by each focus area of our model.

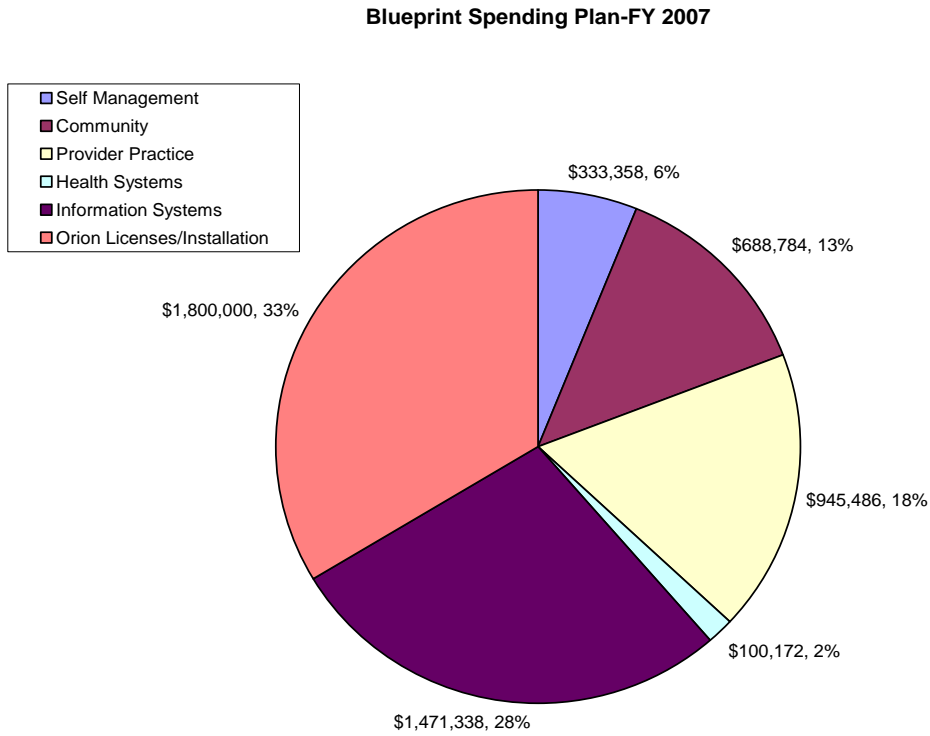


Figure 7: Spending plan for FY 07, by Blueprint focus area; including one time costs for IT licenses, as noted above

Blueprint Challenges

While the Blueprint communities have begun to see successes in a very short period of time, the complexity of the work cannot be underestimated including the critical role of public and private partners at all levels within the health care infrastructure in achieving system transformation of this magnitude. National partners and consultants in the Agency of Healthcare Research and Quality (AHRQ) have provided encouragement as well as caution related to the comprehensive nature of the Blueprint and the pace of system change underway. Areas for careful consideration include the following:

- Health care is the most complex sector of the economy; and the Blueprint is working on system redesign and implementation simultaneously.
- Although the Blueprint public–private partnership is critical to success, it can also be a time consuming process which can slow progress at different points.
- While the Blueprint is a leader in translating knowledge into practice; facilitating the adoption of new evidence-based practice quickly is a challenge. On average, there is a 17-year lag between acquisition of new knowledge and incorporation of this evidence into clinical practice. (Bales and Boran, *Managing Clinical Knowledge for Health Care Improvement*, Yearbook of Medical Informatics, National Library of Medicine, 2000.)
- While evidence-based guidelines exist in the national arena, provider engagement is required for consensus and endorsement, if adoption by practitioners is to be successful.
- Current payment methods do not encourage or support implementation of changes required for “best practice” that leads to improved clinical outcomes. Providers will need to be paid for Blueprint participation in order to move toward performance based payment.
- The reimbursement structure is currently for acute treatment vs. prevention, and chronic care management services. New reimbursement models must be piloted and implemented immediately if significant change is to occur.
- The shortage of primary care providers and the perception of another “unfunded mandate” risks participation by the Vermont primary care providers.

Blueprint Goals for 2007

The Vermont Blueprint for Health creates an overall health system change that can dramatically improve the health of Vermonters and strengthen our state's fiscal health by reducing the need for expensive acute and emergency care. To accomplish this work, the Blueprint has several key goals for the coming year:

- Expand the Blueprint into additional communities and health service areas throughout the state.
- Adopt common clinical guidelines between Blueprint and OVHA, and expand the Blueprint to address additional chronic conditions.
- Implement the Chronic Care Information System (CCIS) in Mount Ascutney HSA and prepare to implement CCIS in the other five Blueprint HSAs.
- Expand the number and geographic availability of the “Healthier Living Workshops” in all HSAs.
- Coordinate self-management services with Medicaid’s Disease Management program and Catamount Health requirements.
- Continue to expand physical activity initiatives statewide in coordination with Fit & Healthy Vermonters.
- Add chronic disease specialists to local Health Department district offices to support community-level work with partners and integration with other programs and activities.
- Assure continued Blueprint alignment with Department of Health Chronic Disease Programs including the Obesity and Fit & Healthy Vermonters initiatives statewide.
- Increase engagement with community coalitions to support disease prevention activities.
- Fund community level health and wellness activities integrated with Coordinated Healthy Activity, Motivation and Prevention Programs (CHAMPPS).
- Continue to expand physical activity opportunities, with special emphasis on environment and policy changes to support sustained behavior change.
- Develop new payment recommendations to reward providers for high quality care and patient wellness.

Public-Private Partnership

A project of the magnitude and complexity of the Vermont Blueprint for Health requires the strong commitment of multiple interests groups and stakeholders if it is to succeed.

To lead this effort, Vermont has forged a strong public-private partnership that includes state government, health insurance plans, business and community leaders, health care providers and consumers.

The supporting organizational structure includes an Executive Committee working with the Commissioner of Health to advise on the strategic approach, and five statewide workgroups that advise and assist staff with planning and evaluation of implementation efforts.

Blueprint for Health Partners

AARP-Vermont Chapter	Department of Aging and Independent Living
Bi-State Primary Care Association	Department of Banking Insurance, Securities and Health Care Administration
Blue Cross Blue Shield of Vermont	Office of Vermont Health Access (Medicaid)
Central Vermont Hospital	Department of Human Resources
CIGNA	University of Vermont
Consumer representatives	-College of Medicine:
Dartmouth Hitchcock Medical Center	Vermont Child Health Improvement Program
Fletcher Allen Health Care	Area Health Education Centers
MVP Health Plan	-College of Nursing and Health Sciences
Mt. Ascutney Hospital	Vermont Association of Hospitals and Health Systems
Northeast Healthcare Quality Foundation (QIO)	Vermont Assembly of Home Health Agencies
Northwestern Regional Hospital	Vermont Business Roundtable
Springfield Hospital	Vermont Medical Society
Southwestern Vermont Medical Center/ United Health Alliance	Vermont Organization of Nurse Leaders
State of Vermont:	Vermont Program for Quality in Health Care
Department of Health	

Appendix

Executive Committee Members

<i>Name</i>	<i>Organization</i>
Sharon Moffatt, RN, MSN; Chair	Vermont Department of Health
Bea Grause, RN, JD; Co-Chair	VT Association of Hospitals & Health Systems
Bill Warnock, ND	Vermont Naturopathic Association
Christine Oliver, JD	Dept. of Banking, Insurance, Securities and Health Care Administration
Don George	Blue Cross Blue Shield of Vermont
Helen Riehle	VT Program for Quality in Health Care
James Hester	MVP Health Care
Joshua Slen	Office Of Vermont Health Access
Mark Novotny, MD	Southwestern Regional Hospital
Michael Sirois, MD	Community Health Center
Patrick Flood	Dept. of Disabilities, Aging and Independent Living
Paul Harrington	Vermont Medical Society
Thomas Murray	Department of Innovation and Technology

Blueprint Staff

- Jessica Porter, RN, JD; Chief, Blueprint for Health, 951-4004
- Eileen Girling, RN, MPH; Director, Blueprint Implementation, 865-7705
- Mary Woodruff, MPH, RD; Self-Mgt. Program Administrator, 652-2097
- Lisa Dulsky Watkins, MD; Public Health Physician, 652-2095
- Kelly Dougherty, MSW, MPH; Community Program Administrator, 652-2094
- Jeremiah Sable, MD, MHA; Public Health Physician, 652-2093
- Eugene Bifano; CCIS Project Manager, 863-7344

Blueprint Workgroup Members (Co-chairs in bold; Blueprint staff in italics)

Self management

Sarah Narkewicz (Bowse Health Trust-RRMC)
Mary Woodruff (VDH)
Robin Edelman (VDH)
Amy Nickerson (DAIL)
Beth Kuhn (Champlain Initiative)
Don Dickey (JFO)
Elizabeth Cote (UVM/AHEC)
Fran Joseph (CVAHEC)
Jean McCandless (VDH/Arthritis Program)
Kathryn Kaminski (DHMC)
Kristy Sprague (OVHA)
Laural Ruggles (NVRH)
Laurinda Poirier-Solomon (FAHC)
Lori Smith (FAHC)
Margo Caulfield (Chronic Conditions InfoNet)
Marianne Ward (Consumer)
Nancy Abernathy (FAHC)
Nancy Frank (NEV-AHEC)
Nick Nichols (VDH/Mental Health)
Pam Cross (NWMC)
Patricia A. Launer (VPQHC)
Peggy Carey (FAHC)
Sheri Lynn (VDH)
Ruth Ann Rhodes (Community Health Ctr., Burlington)
Sharon Gutwin (RehabGYM)

Community

Joan Senecal (DAIL)
Kelly Dougherty (VDH)
Amy Bell
Anne Ferguson (VDH/Barre DO)
Amy Nickerson (DAIL)
Fran Joseph (CVAHEC)
Heidi Joyce (Vt. League of Cities and Towns)
Jennifer Wallace Brodeur (AARP)
Jenny Patoine (NEVAAA)
Karen Garbarino (VDH)
Kristy Sprague (OVHA)
Linda Berlin (UVM Extension Service)
Linda Shaw, RN (Copley Hospital)
Lori-Anne Russo (Southwestern Vermont Medical Center)
Martha Maxsym (United Way)
Mary Ellen Mendl (United Way)
Michele Leno (Central VT Hospital)
Pam Farnham (FAHC)
Susan Coburn (VDH)
SuzanneKelley(VDH)

Provider Practice

Mark Novotny, MD (Southwestern VMC)
Donna Izor (Central. VT Med Ctr)
Lisa Dulsky Watkins, MD
Alison White (Central. VT Med Ctr)
Ann Collins (CIGNA)
Bob Schwartz, MD (Northshire Medical Center)
Bradley Berryhill, M.D. (Castleton Family Health)
Charles Maclean, MD (UVM/AHEC)
Cy Jordan, MD (VPQHC)
Dana Krause, MD (NCHCVT)
Don Swartz, MD (VDH)
Jerry Sable, MD
Jerry Salkowe, MD (MVP)
John King, MD (Milton Family Practice)
Norm Ward, MD (FAHC)
Paul Harrington (VT Medical Society)
Peter Park, MD (Deerfield Valley Health Center)
Rob Penney, MD (Provider)
Russ Davignon MD (Central VT Med. Ctr)
Scott Strenio, MD (OVHA)
Steve Perkins, MD (BC/BS)
Tonya Howard, NP (Northern Counties Healthcare)
Consultants:
Josh Slen, Director OVHA
David Gorson, MD, (Southwestern VMC)

Health Systems

Paul Harrington (VT Medical Society)
Helen Riehle (VPQHC)
Lisa Dulsky Watkins, MD
Andrew C. Stanley, MD (FAHC)
Barbara Walters, MD (DHMC)
Don Dickey (Joint Fiscal Office/VT Legislature)
Don George (BC/BS)
Frank Provato, MD (TVHP/BCBS)
Greg Peters (Consultant)
Hunt Blair (BI-STATE PCA)
James Duncan, MD (VT Managed Care)
James Mauro (BCBS)
Jill Olson (VAHHS)
Joan Haslett (DAIL)
John O'Kane (IBM)
Kathy Callahan (Vt. Dept. of Personnel)
Karyn Patno, MD (Provider)
Ken Deon (KPMG)
Kim Aakre (VDH)
Lawrence Ramunno (Northeast Healthcare Quality Foundation)
Lou McLaren (MVP Healthcare)
Pat Jones (BISHCA)
Scott Strenio, MD (OVHA)
Simon Rosenstein (Great-West)
Stephen LeBlanc (DHMC)

Information Systems

Art Limacher (VDH)
Jim Hester (MVP)
Gene Bifano (VDH)
Andrea Lott (Northeastern VT Regional
Hospital)
Craig Morton (DHMC)
Curtis Kerbs (CVPHO)
Cy Jordan, MD (VPQHC)
Ed Bernard
Eileen Girling (VDH)
Glenn Thorton (DHMC)
Greg Farnum (VITL)
Hans Kastensmith (American HMC)
Hunt Blair (Bi-State Primary Care)
Jerry Sable, MD
Jessica Porter (VDH)
Judy Higgins (AHS)
Lawrence Ramunno, MD (NE Health Care
Quality Foundation)
Laurie Hurowitz (AHEC)
Mike Gagnon (FAHC)
Norm Ward, MD (FAHC)
Paul Harrington (VT Medical Society)
Peter Marsh (VDH)
Peter Schickler
Rich Ogilvie (PHIN)
Thomas Murray (AHS Information
Technology)
Thomas Sims

Evaluation

Eileen Girling (VDH)
Jennifer Hicks (VDH)
Brendan Hogan (OVHA- VT Medicaid)
Ellen Thompson (VDH)
Jennifer Fels (United Health Alliance)
Joyce Gallimore (MVP Health Plan)
Kelly Dougherty (VDH)
Lisa Dulsky Watkins, MD (VDH)
Mary Woodruff (VDH)
Paul Harrington (VMS)
Robert Hockmuth, MD (CIGNA)
Steve Perkins, MD (BC/BS)
Tom Delaney (VCHIP)