

AMENDMENT

It is agreed by and between the State of Vermont, Agency of Human Services, **Department of Vermont Health Access** (hereinafter called "State") and **Northeastern Vermont Regional Hospital** (hereinafter called "Grantee") that the grant agreement between the State and Grantee for the Blueprint for Health Program, dated July 1, 2010 is hereby amended as follows:

By deleting on page 1 of 23, Item # 3 (Maximum Amount) and substituting in lieu of thereof the following:

3. Maximum Amount: In consideration of the services to be performed by Grantee, the State agrees to pay Grantee, in accordance with the payment provisions specified in Attachment B, at sum not exceed **\$382,317.56**.

By deleting pages 3-5 of 23, Attachment A (Specifications of Work to be Performed) and substituting in lieu thereof, the following:

GENERAL PURPOSE STATEMENT

Overview

Vermont's 2010 Health Care Reform legislation (Act 128) states, "The Commissioner of Vermont Health Access shall expand the Blueprint for Health as described in chapter 13 of Title 18 to at least two primary care practices in each hospital services area no later than July 1, 2011, and statewide to primary care practices who wish to participate no later than October 1, 2013." Further, "No later than July 1, 2011, hospitals shall participate in the Blueprint for Health by creating or maintaining connectivity to the state's health information exchange network as provided for in this section and in section 9456 of this title."

In this grant cycle, subrecipients will be supported in the transition toward becoming a Blueprint Multi-payer Advanced Primary Care Practice (MAPCP) model community. This spectrum consists of three possible levels of development as outlined below and HSAs will move along the spectrum during this grant cycle:

Phase I: Establishing 2 local planning work groups for a) Clinical planning including Community Health Team (CHT) structure and preparation for practices to be scored as APCPs, and b) Information Technology readiness. Implementation will start during this phase.

Phase II: NCQA PPC-PCMH scoring by VCHIP, signing of Business Associate Agreements (BAA) with VITL/VHIE and DocSite as appropriate, initial work on IT, and building of CHT infrastructure starting with care coordination and practice transformation. Movement toward MAPCP model will be supported and must be demonstrated as outlined in Act 128 rules and as described in this document.

Phase III: NCQA PPC-PCMH recognition, full CHT operations, effective use of the Blueprint Registry (DocSite) and full payment reform. Achievement of MAPCP model criteria demonstrating compliance with Act 128 rules and as described in this document.

Many subrecipients will be engaged in activities that cross Phases of MAPCP development. In all 3 Phases, subrecipients are required to cooperate with the Quality Improvement efforts and the Blueprint Evaluation (described in the Evaluation section of this document).

In all phases, subrecipient must involve willing local independent, hospital-owned and parent organization owned practices in Blueprint planning efforts. In addition, Subrecipient must demonstrate active involvement of all willing local independent, hospital-owned and parent organization owned practices in these efforts and activities.

SPECIFICATION OF WORK TO BE PERFORMED AND PERFORMANCE STANDARDS

As of October 1, 2010, Northeastern Vermont Regional Hospital HSA is in Phase III of MAPCP development

No funds can be drawn from this grant until the subrecipient has submitted revised work plan, which has been approved by the Blueprint Associate Director. The approved work plan is due within 30 days of the final execution of this grant amendment.

Project Management (Phases I, II and III)

- Subrecipient shall identify the Project Manager, submit a copy of the Project Manager's resume, and indicate the proportion of a full time equivalent position to be dedicated. If no Project Manager has yet been identified, a plan for hiring must be submitted.
- Project Managers are expected to work collaboratively with the Blueprint leadership and team. Regularly scheduled meetings include but are not limited to monthly conference calls and quarterly in-person meetings. Project Managers may also be asked to attend periodic events including local site visits, the Blueprint Annual Conference and/or other ad hoc meetings.
- The local Blueprint Project Manager or designee will participate in the Expansion Design and Evaluation Committee and the Payer Implementation Work Group.
- The Project Manager will be the primary local contact responsible for overseeing all components of the grant.
- The Project Manager should have sufficient time allotted by the HSA grant recipient to effectively coordinate these activities. The Blueprint expects that a Project Manager should be at least 0.5 FTE.

Healthier Living Workshops (HLW) Phases I, II and III

Staffing:

Healthier Living Workshop (HLW) Regional Coordinator: Subrecipient must designate a local regional coordinator to oversee the local planning, coordination and implementation of the Healthier Living Workshops. Regional coordinators are expected to participate in regular conference calls and one in person meeting annually with the Blueprint team. The regional coordinator will be the primary local contact responsible for overseeing the program.

1. HSA's are asked to continue to build their infrastructure and capacity by:

a) Faculty retention

- Ensure master trainers lead a leader training at least once every 12 months to maintain their certification.
- Host local leaders meetings on a regular basis
- Follow-up with inactive leaders
- Notify the Blueprint of any changes in the status of HLW leaders
- Facilitate leaders attending any statewide leader events hosted by the Blueprint for Health

b) Program Effectiveness

- Review HLW evaluations and develop an action plan to address areas that can be improved by the regional coordinator related to the logistics of the workshop.
- Review program evaluations with leader pairs following each workshop, developing an action plan with the leaders to address any areas for improvement related to workshop facilitation and fidelity.
- Plan and coordinate audits. To maintain certification each leader will need to have at least one class they teach audited by an approved auditor every 2 years. Audit forms must be sent to the Blueprint within 5 business days of the audit.

c) Partnership - Collaboration with the Area Agency on Aging (AAA) and community partners to enhance capacity, including:

- Meeting at least twice annually with the AAA and DVHA District Office to review process and evaluation data and from that data to develop a plan to address any issues identified or to improve the implementation of the program.
- Assisting the AAA in assessing the effectiveness of marketing materials to reach older adults
- Working with the AAA to identify new sites to offer the program that best meet the needs of older adults
- Working with the AAA to connect clients to resources to overcome individual or group barriers to attending the program such as transportation and respite care.

2. HSA will coordinate the logistics to host 4 to 6 HLW, HLW-Diabetes, or HLW-pain.

a) Workshops

Subrecipient should plan to:

- Implement 4 - 6 workshops annually (a combination of HLW, HLW-diabetes, or HLW-Pain)
- Schedule and coordinate all leader and facilities logistics for workshops.
- Pay all leader stipends and expenses.
- Purchase course materials from publisher or other commercial source
- Participate in the HLW statewide program evaluation, submitting required information and reporting forms as specified and supplied by the State within the specific time frames outlined by the State including:
 - Workshop scheduling forms are due electronically as soon as a workshop is scheduled.
 - Notify the Blueprint of any workshops that are cancelled and why it is cancelled, as soon as possible.
 - The initial Attendance sheet with registration information and first session attendance and hard copy PAMS are due no later than 5 business days after the first of the six sessions in a Healthier Living Workshop.

- Completed final Attendance forms and Healthier Living Workshop Evaluation Forms are due no later than 5 business days after the last of the six sessions in a Healthier Living Workshop. Special attention should be given to capture the names of everyone who registers for a workshop, the dates that they attend, the reason participants miss a class and the reason(s) a person decides not to attend or to drop out.

- b) Participant Recruitment: Employ low cost effective marketing strategies to recruit at least 12 participants per workshop (minimum attendance goal for HLW is 10 people). Sub-recipients should:
 - Integrate HLW marketing into existing community outreach and marketing efforts of the hospital and affiliated organizations including working with the diabetes education and tobacco cessation programs.
 - Outreach to health care providers throughout the region to refer patients to HLW.
 - Develop or incorporate HLW referrals into existing health care provider referral systems such as diabetes education and tobacco cessation.
 - Work with the Federally Qualified Healthcare Centers in the region to refer patients to HLW or to host workshops.
 - Recruit State employees to participate in HLW working with the Summit Center and Blueprint staff.
 - Assure local capacity to accept referrals to HLW's for Catamount Health, Medicaid, and State employees as outlined in Act 71.
 - Monitor the source of referrals (including provider referrals) based on outreach efforts to evaluate strategies and success; and guide revision of outreach effort

Phase III

During Phase III, subrecipient will continue with many of the activities they accomplished during Phase II, including:

Information Technology

Practices, practice parent organizations and hospitals will have agreements in place with Vermont Information Technology Leaders (VITL) and DocSite. Written plans with timelines or demonstration of work underway for the following:

- Updating of EMRs against core data elements in the DocSite data dictionary
- Creation of interfaces between local electronic systems and the VHIE
- Transmission of core data elements in the DocSite data dictionary to DocSite (either directly or through the VHIE)

VITL project management will work closely with key contacts in practices, parent organizations and hospitals to support this work. The goal is an architecture that allows clinicians to use the clinical tracking system of their choice (e.g. EMR, registry) for patient care, care coordination, population management, and performance reporting, while populating the Blueprint registry with core data elements. The registry will be available to participants to support: individual patient care; population management and outreach; performance reporting; and, quality improvement efforts. Subrecipients must provide plans for and progress reports on this activity.

Community Health Team

Subrecipient will maintain the Community Health Team (CHT). The ultimate size of the CHT will be determined based on the cumulative population (active case load) served by participating practices at a ratio of 5 FTEs per a general population of 20,000. (The general population is defined as the number of unique individuals seen by the primary care practice in the last 2 years.) Local multi-disciplinary core CHTs continue to support practices and patients with direct and barrier-free access to

- care coordination
- managing referrals and interactions with specialty care
- multi-modal strategies to facilitate transition from acute care to the primary care setting
- education related to health conditions
- treatments, and lifestyle changes
- assistance with planning self management goals and tracking progress
- counseling for behavioral, mental health, and substance abuse issues
- connections to social, economic, and other community support services.

In addition to individual support, the core CHT will continue to help practices with population management by pulling reports, conducting outreach, and facilitating follow-up and assessments for targeted populations. Patients are connected to services such as applying for insurance, securing housing and transportation, seeking economic assistance, assistance in purchasing and managing medication, accessing physical activity resources and nutritional counseling, and enrolling in self-management programs. Transitions from the hospital setting to the primary care/CHT are of particular interest to the Blueprint. Prompt/close phone and in-person follow-up are to be a priority of the care coordinator. A Public Health Chronic Disease Prevention Specialist based at the local Vermont Department of Health District Office must be on the CHT, working to identify local priorities and opportunities for evidence based prevention programs.

CHT members shall continue to meet regularly with providers and staff to identify: targeted populations; opportunities for improvement; plan care coordination strategies; and, assure a team based approach across independent practices and organizations. Weekly meetings are recommended, but schedules will need to be flexible. The CHT shall continue to document their activities in a manner that populates the elements in the DocSite CHT Visit Planner. Subrecipient must provide documentation of CHT planning and activities.

Clinical Transformation

Subrecipients must work collaboratively as part of the Expansion and Quality Improvement Program (EQuIP). This will include working with trained Blueprint Practice Facilitators and trained local QI Coaches to support ongoing data guided quality improvement and refinement of the program, with the ultimate goal of assuring ready access to well coordinated health services for patients. The EQuIP facilitators will support and assist primary care practices in implementing and managing process transformation including:

- improving access to the primary care practice
- well coordinated services and care transitions
- meaningful use of information technology systems such as registries (DocSite) and portals to improve patient care

- integration of self-management support, shared decision making, and planned care visits
- redefining roles and establishing team-based care
- seamlessly connecting with community resources and specialty referrals.

Phase III represents the full maturity of the Vermont Blueprint Multi-payer Advanced Primary Care Practice (MAPCP) model. All activities in Phase II must be completed. Certification requirements for the practices are as follows:

- a) Validation by NCQA of a PPC-PCMH score of 25 or higher and achieving a minimum of 5 “must pass” elements.
- b) A Letter of Support from a local entity recognized by the Blueprint as a Community Health Team lead sponsor for an active or developing Community Health Team.
- c) A Letter of Commitment to a local entity recognized by the Blueprint as a Community Health Team lead sponsor for an active or developing Community Health Team.
- d) A Memorandum of Understanding or similar document executed between the practice and Community Health Team lead sponsor may be substituted for b and c.
- e) Completion of an Expectations of Participation work sheet documenting how the applicant will meet the Expectations detailed in *The Vermont Blueprint Applicants Guide* (available by November 30, 2010).
- f) Completion of core Blueprint health information technology (HIT) requirements including submission of a Blueprint HIT Requirements Check List.
- g) Completion of Quality Improvement Agreement to work with the Blueprint facilitators and Community Health Team members as part of a Learning Health System.
- h) Completion of a Blueprint Evaluation Participation agreement.

Recruitment of all willing providers (independent or employed by a parent organization or hospital) occurs as part of the ongoing planning and implementation process in each HSA.

Evaluation

Subrecipients are required to support the Blueprint Evaluation via the following as possible: entry of structured data into the electronic health record of their choosing (e.g. practice and hospital-based electronic health records, Blueprint Registry); support transmission of patient information including Blueprint core data elements from their electronic health record through the VITL HIE to the Blueprint registry; support the chart review process conducted by VCHIP; support the NCQA PPC-PCMH assessments conducted by VCHIP; support qualitative assessments of program experience conducted by VCHIP; participate in organized quality improvement activities in your HSA that include planning ongoing improvement of the health services model based on review of quality reports produced by centralized data sources (Blueprint registry, Multi-payer database, chart review). As much as is possible, the evaluation will be conducted using data that is collected as part of routine daily clinical operations (EMR to Registry, Hospital to Registry, Multi-payer claims database), or with data that is

collected by an independent third party (UVM VCHIP team). Program objectives and evaluation methods will be described in the Blueprint Implementation Guide. Subrecipient should demonstrate the commitment to participate in the Blueprint evaluation efforts and submit all meeting minutes associated with Blueprint activities in your HSA as well as a mid-year financial and program report addressing individual components of this grant.

Available Funding and Financial Match

Funding for local infrastructure and implementation will vary and requires a 25% match as evidence of local commitment to sustaining the Blueprint.

By deleting page 8 of 23, Attachment B (Payment Provisions, Approved Budget) and substituting in lieu thereof, Attachment B, which is included below.

Department of Vermont Health Access
 Financial Report Form
 Original Budget

Subrecipient Name: Northeastern VT Regional Hospital		
Grantee's/Contractor's Contact Person: Laural Ruggles		
Grantee's/Contractor's Email Address: l.ruggles@nvrh.org		Phone: 802-748-7590
	TOTAL GRANT/CONTRACT BUDGET	Match
PERSONNEL		
Salaries and Benefits		
Laural Ruggles	-	47,250.00
Andrea Lott	-	10,000.00
Paula Gaskin	-	10,000.00
Joyce Dobbertin, MD	10,000.00	10,000.00
Pam Smart	29,600.00	
Shauna Barrett	29,600.00	
Mitya Schoppe	29,600.00	
Janice Duncan	22,600.00	
Sub Grantee/Sub Contractors		
Sharon Fine, MD	10,000.00	10,000.00
Dana Kraus, MD	10,000.00	10,000.00
Julie Riffon	-	10,000.00
Allison Wright Roberts	31,800.00	
Donna Ransmeier	31,800.00	
HLW Stipends	3,600.00	
Total Personnel	208,600.00	

OPERATING		
Advertising/Marketing		1,500.00
Training		
Travel		2,020.00
Postage		
Supplies/Materials		2,880.00
Printing		
PPPM Medicare Physician Incentive	167,317.56	
Total Operating	173,717.56	
INDIRECT COSTS/ADMIN		
List		-
Total Administration		-
TOTAL GRANT/CONTRACT AMOUNT	382,317.56	107,250.00

Per Patient Per Month (PPPM); and Community Health Team (CHT) costs will be paid distributed as follows:

CHT Costs		
Medicaid CCT costs		\$70,000.00
Medicare CCT costs		\$70,000.00
MVP Subsidy		\$35,000.00
CHT TOTAL		175,000.00
PPPM Costs		
Corner Medicare Patients	3175 X 1.52 X 12	\$57,912.00
Concord Medicare Patients	769 X 1.52 X 12	\$14,026.56
Caledonia Medicare Patients	1521 X 2.00 X 12	\$36,504.00
Danville Medicare Patients	1237 X 2.00 X 12	\$29,688.00
St. J Medicare Patients	1175 X 2.07 X 12	\$29,187.00
PMPM TOTAL		\$167,317.56
Program Costs		
HLW budget		\$10,000.00
Project Management (9 months October 1, 2010 – June 30, 2011)		\$30,000.00
PROGRAM BUDGET TOTAL		\$40,000.00
Grant Total		\$382,317.56

Variances of the budgeted lines items shall not exceed 10% without prior approval from State. Written requests for such approvals must first be submitted by the Grantee prior to the expenditure of funds in excess of the above budgeted line items.

By deleting on pages 6 and 7 of 23, Attachment B (Payment Provisions), and substituting in lieu there of the following:

ATTACHMENT B - PAYMENT PROVISIONS

The State will pay Subrecipient the sum not to exceed \$382,317.56. This amount will be paid in the following manor:

A final financial report will be due no later than 30 days after the end date of the Grant. The final financial report will report actual approved expenditures against payments received.

Subrecipient will invoice the Department of Vermont Health Access (DVHA) on a monthly basis, for the previous month's actual and approved expenditures. Monthly invoicing in arrears will continue through the life of the grant. The maximum payable amount under this Grant shall not exceed \$382,317.56.

The State will pay invoices of actual expenses upon receipt of the DVHA Financial Report Form with documentation of expenses and all other required reports in Attachment A and Attachment B; when in receipt of an invoice with supporting documentation articulating actual expenditures for approved activities during the said time period. **The Financial Report Form and the supporting documentation will be sufficiently detailed to allow the reviewed to match invoiced expenses against approved budget line items.**

Subrecipient agrees to provide DVHA all meeting minutes associated with the Blueprint for Health initiative, during the grant time period. Meeting minutes will be sufficiently detailed document movement toward and achievement of deliverables noted in Attachment A. Meeting minutes will include the names of the attendees as well as the facility they represent. Meeting should represent non-hospital/parent owned practices/facilities. **All subrecipients, no matter what phase of development are required to continually involve non-hospital owned/non parent owned practices in ongoing planning efforts**

On or before April 30th 2011, Subrecipient will submit a mid-year report include a financial report (which will report actual approved expenditures against payments received); and, a program report addressing projects in your approved work plan.

A final expenditure report is due no later than 30 days after the end of the grant and will be reconciled to actual costs incurred for the grant term. Any overpayment of expenses will be returned to the State no later than 60 days after the end of the grant term.

All reports related to this grant should be submitted in electronic format. Reports should reference this grant number and be submitted to:

Lisa Dulsky Watkins MD
Department of Vermont Health Access
312 Hurricane Lane
Suite 201
Williston, Vermont 05495-2806
Lisa.Watkins@ahs.state.vt.us

An electronic copy of all reports and a **hard copy of invoices with original signature** should be sent to:

James R. Morgan MSW
Department of Vermont Health Access
312 Hurricane Lane
Suite 201
Williston, Vermont 05495-2806
Jim.Morgan@ahs.state.vt.us

The state reserves the right to withhold part or all of the grant funds if the state does not receive timely documentation of the successful completion of grant deliverables.

This amendment consists of 10 pages. Except as modified by this amendment and any previous amendments, all provisions of this grant (#03410-6104-11) dated July 1, 2010 shall remain unchanged and in full force and effect.

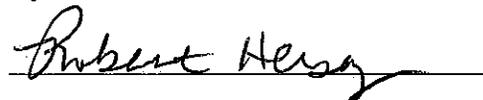
IN WITNESS THEREOF, the parties set forth below agree to execute this Amendment:

STATE OF VERMONT

GRANTEE

By:

By:



Susan Besio, Commissioner
Department of Vermont Health Access

Date: 10/12/10

Date: 10/06/10

