1. Thank you, Madam Chair, for inviting me to present to your committee this morning. I am looking forward to reviewing the Blueprint for Health with you all.

2. The Statutory Framework for the Blueprint for Health was established in 2010 for ACT 128. The Blueprint has 15 years of experience as to how Healthcare is distributed statewide.

3. Through research, design, and implementation of innovative health care delivery and payment models, the Blueprint remains a multi-payer, whole-population program that can develop and test health care reform initiatives. As an innovation engine, it has implemented concrete and durable changes to treatment delivery, payment models, and health care information systems, particularly related to integrated primary and community care.

4. The Blueprint for Health is ambitious in its goal for Vermonters' primary care providers to be supported in taking a long-term, whole person approach to care—one that addresses medical, social, and mental health needs and provides access to a range of supportive services—in an integrated fashion. For Primary Care Providers, the Blueprint for Health can encourage an expanded focus on the needs of the entire population they serve. The program has offered support through delivery system reform and payment models that give primary care more ability to invest time and resources in team-based, data-driven, quality focused care.

5. In accompaniment to this slide, I have provided you with the additional document entitled "Blueprint for Health Internal and External Return on Investment (ROI) References"
   There have been internal and external ROI evaluations of the Blueprint which have shown positive results including:
   - *Evaluation of the Multi-Payer Advanced Primary Care Practice (MAPCP) Demonstration: Final Report*
   - *Peer-reviewed publication by Jones et al in 2016*

As well as...
- *St. Johnsbury Vermont Community Health Team: Evaluation Summary*
- *And Blueprint annual reports from 2013-2017*

6. The Blueprint Executive Committee is defined in statute by the members representing departments at the Agencies of Human Services including the Department of Health, Department of Mental Health, and the Department of Vermont Health Access, as well as a representative from the Green Mountain Care Board. Two private health insurers are represented, healthcare professionals who provide health services, as well as health care associations and consumers. Representative Houghton is an individual appointed jointly by the President Pro Tempore of the Senate and the Speaker of the House of Representatives.

7. Health Service Areas (HSAs) represent the areas in which patients receive their healthcare, and historically have been defined by which hospital they have been discharged from. Blueprint utilizes HSA to help ensure that resources are distributed across the state in a way that is accessible to most people, also shown here are the current program managers.

8. Each Administrative Entity hires a Blueprint Program Manager to oversee the Blueprint activities in an HSA.
    - The Program Manager will be the primary local contact responsible for management of all programmatic and administrative components of the agreement.
    - They will provide support and help in the development of effective strategies in alignment with grant and program deliverables.
    - They will establish key relationships with patient centered medical homes, community partners, regulators, and governmental agencies.
    - The BP Program Manager is a key liaison for BP trainings, strategic direction, coordination and support in developing and spreading best practices.

9. Next, I will be reviewing BP programs, including:
    - Patient-Centered Medical Homes & Quality Improvement Facilitation
    - Community Health Teams
    - Hub & Spoke system for Opioid Use Disorder Treatment
    - Pregnancy Intention Initiative

10. The Blueprint was founded on the establishment of Patient Centered Medical Home recognition by the National Committee for Quality Assurance. Practices that meet these standards have been shown to help better manage chronic conditions, improve quality, and are associated with lower health care costs. The Blueprint supports practices that become recognized as PCMHs through additional payments to support their work. These payments are made by public and private health insurers directly to the practice. The practice and practitioners know them, understands their health history, needs, preferences and takes into consideration prevention, new, and long-standing health care needs and goals. There is expanded access to the provider and care team through electronic communication, extended hours, after hours coverage. Screening procedures are done regularly based on the patient's age and gender. There is assistant with managing various specialists, referral, referral follow up, care planning and care coordination. All together it's an approach to care that emphasizes and supports informed decision making, motivational interviewing, patient centered goal setting and self-management of chronic conditions. The Blueprint also supports PCMH practices by providing each with a Quality Improvement Facilitator. This is a professional who uses evidence-based tools to help the practice meet key health care quality metrics and make sure that they are maintaining NCQA recognition.

11. The PCMH payments that the committee sees on the left side of the screen represent the current per member per month amount paid by commercial, Medicare, and Medicaid

payers. The Commercial and Medicaid payments have not been increased since 2016. The Medicaid payment is higher than the Commercial payment because it incorporates a preexisting capitated payment for managed care services. The Medicare amount is based on available shared saving amounts from the all-payer model agreement. Half of the performance payment is based on health care utilization of the patient population of individual practices up to 25 cents per member per month, the other half is based on hospital service area population healthcare quality measures up to 25 cents per member per month.

12. To give the committee an idea of how these payments could accrue for a small practice of providers, I present you with an example of the dollar amounts per insurer as well as the total per month that would be paid. This funding is used at the discretion of the practice for activities related to maintaining its Patient Centered Medical Home recognition and the activities therein.

13. Community Health Teams supplement the services available in Patient-Centered Medical Homes and link patients with the social and economic services that make healthy living possible for all Vermonters. The Community Health Team staff are intended to provide supports and services that are not generally covered by insurance, at no cost to the patient and without regard to insurance status. These staff may include social workers, care coordinators, mental health counselors, dieticians, community health workers, and other types of professionals who provide support and whole person care. The Community Health Team staff are intended to provide supports and services that are not generally covered by insurance, at no cost to the patient and without regard to insurance status.

14. One of the key functions of the Community Health Team is to serve as an access point to specialty supports and services already existing where the patient lives. These may include food, housing, and transportation services, specialty and parent disease management, and others included on this slide.

15. The Blueprint supports the staffing of the Community Health Team by directing public and private health insurers to make payments to an “Administrative Entity” in each region of the state (usually the local hospital). Blueprint-funded Program Managers oversee the outflow of funds to local practices to make sure that the needs of the community are being met and that practices have the appropriate level of support. Medicare funding availability has not kept up with past payment increases of both Commercial and Medicaid.

16. Similar to the example I presented to the committee for PCMH Payments, this slide depicts funding to one administrative entity based on an attributed population of 12,866 individuals.

17. In addition to the Community Health Teams, there are two additional key programs sponsored by the Blueprint that patients may interact with in their Patient Centered Medical Homes. Hub and Spoke is Vermont's system of treatment for opioid use disorder (OUD). Nine Regional Hubs under the direction of the Department of Health offer daily support for patients with complex addictions.

18. At over 75 local Spokes, doctors, nurses, and counselors offer ongoing OUD treatment fully integrated with general healthcare and wellness services. This framework utilizes medication for opioid use disorder (MOUD) for treatment and efficiently deploys OUD expertise through bidirectional movement between Hub and Spokes to expand access to OUD treatment for Vermonters.

19. As you can see, in the right-hand column, there has been a rise of patients served, providers and staff hired since the program's inception.

20. The Pregnancy Intention Initiative helps ensure that women's health providers, Patient Centered Medical Homes, and community partners have the resources they need to help women be well, avoid unintended pregnancies, and build thriving families. In 2017, the Pregnancy Intention Initiative/Women's Health Initiative/WHI was begun in an effort to increase the intended pregnancy rate. As of 2020, the Intended Pregnancy rate in Vermont was 57.1, which is an increase from 55.9 in 2018. In front of you, there are multiple components for comprehensive family planning counselling, as well as psychosocial screening, intervention, and navigation to services. One Key Question is defined as asking patients "Would you like to become pregnant in the next year" and providing counselling. (PRAMS – Pregnancy Risk Assessment Monitoring System)

21. As of 2022, attributed patients 22,000 payment schemes include a per member per month of $1.25. Support for staffing, either through the community health team, or through OBGYN Practices, and a one-time per member payment to support stocking of most and moderate effective contraception such as Long-Acting Reversible Contraceptive devices to practices. Through the Pregnancy Intention Initiative, people who can become pregnant receive substantial preventive care services in OB-GYN and women's health clinic settings. Through the Pregnancy Intention Initiative, women's health specialty providers Blueprint Patient Centered Medical Homes are providing enhanced health and psychosocial screening along with comprehensive family planning counseling and timely access to long-acting reversible contraception (LARC). New staff, training, and payments support effective follow-up to provider screenings through brief, in-office intervention and referral to services for mental health, substance use, trauma, partner violence, food, and housing.