Report to

The Vermont Legislature

Annual Report on
The Vermont Blueprint for Health

In Accordance with

18 V.S.A. §709: Blueprint for Health, Annual Report

Submitted to	**House Committee on Health Care; Senate Committee on Health and Welfare; and Health Reform Oversight Committee**
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VERMONT
AGENCY OF HUMAN SERVICES

VERMONT Blueprint for Health

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Executive Summary

Legislation & Report Contents

18 V.S.A. § 709. requires the Blueprint for Health (Blueprint) to make an annual report to the legislature:
(a) The director of the Blueprint shall report annually, no later than January 31, on the status of implementation of the Vermont Blueprint for Health for the prior calendar year and shall provide the report to the House Committee on Health Care, the Senate Committee on Health and Welfare, and the Health Care Oversight Committee. (b) The report required by subsection (a) of this section shall include the number of participating insurers, health care professionals, and patients; the progress made in achieving statewide participation in the chronic care management plan, including the measures established under this subchapter; the expenditures and savings for the period; the results of health care professional and patient satisfaction surveys; the progress made toward creation and implementation of privacy and security protocols; information on the progress made toward the requirements in this subchapter; and other information as requested by the committees. The provisions of 2 V.S.A. § 20(d) (expiration of required reports) shall not apply to the report to be made under subsection (a) of this section.

The Vermont Blueprint for Health (Blueprint) was established to promote high quality primary care that is integrated with services that affect health and wellbeing but are delivered outside of the medical setting. Supported by multi-payer participation, the Blueprint creates a foundation of primary care based on the patient-centered medical home (PCMH) model and bolstered by multi-disciplinary Community Health Teams (CHTs). These teams provide care coordination and linkages to services across the care continuum. Essential to the success of the PCMHs and CHTs is a network of locally hired Program Managers, Community Health Team Leaders, and Quality Improvement Facilitators. This network has been integral to facilitating local transformations and increasing collaboration across community partners.

Building on the PCMH and CHT model, the Blueprint program has expanded to include the Hub and Spoke System of Care for individuals with opioid use disorder (OUD) and specifically supports primary care practices providing medication-assisted treatment (MAT). The Blueprint also created the Women's Health Initiative to ensure access to services that support pregnancy intention.

The Blueprint is a demonstrated leader in establishing a statewide network of PCMHs supported by CHTs focused on integrating care and services. The Blueprint model adds a per-member per-month payment for coordinating primary care services and improving quality and value performance on top of existing fee-for-service payments to primary care. Building on the Blueprint's foundation, Vermont's All-Payer Accountable Care Organization (ACO) Model advances additional payment and delivery system reform initiatives to move the state more aggressively away from fee-for-service. To accelerate the Blueprint's complementary function with large scale payment reform, the Blueprint for Health has been relocated within the Office of Health Reform in the Secretary's Office at the Agency of Human Services along with the Health Information Exchange initiative, allowing for greater coordination with the Agency of Human Services' field teams and the Vermont Chronic Care Initiative.

Community-Based Facilitation of Health Reform

The network of local health reform leaders, which includes Blueprint Program Managers, Quality Improvement Facilitators, and Community Health Team Leaders, is one element that has differentiated the Blueprint's approach from other health care reform efforts. This network is essential to the Blueprint's objective of continuously strengthening local health systems to provide care coordination, advance population health goals, and manage cost risks arising from shifts to value-based payments

The positions in this network are supported through the Blueprint's Global Commitment to Health-funded grants made to the local Administrative Entities, which are either the local hospital or FQHC, with

supplemental funding from regional health care organizations. In addition to funding this network, the Blueprint provides participants with oversight, coaching, educational offerings, and peer-to-peer learning opportunities. This system of regionally based Program Managers, Quality Improvement Facilitators, and Community Health Team leaders is the foundation upon which other evolving health reforms are and can be built, with payments to local systems resulting in staffing on the ground to accomplish reform goals.

Blueprint for Health Services

Vermont's **Patient-centered Medical Home (PCMH)** model supports care for all patients that is patient-centered, team-based, comprehensive, coordinated, accessible, and focused on quality and safety, regardless of insurance type. The model is based on the National Committee for Quality Assurance (NCQA) criteria, which are required for Blueprint participation and have been met by almost all of Vermont's primary care practices. These 134 PCMHs currently serve 304,526 insurer-attributed patients. Payers, including Medicare, Medicaid, and major commercial payers in Vermont, make per member per month (PMPM) payments directly to practices based on the number of the payer's patients attributed to each practice. In 2021, the 134 primary care practices (or their parent organizations) collectively received an estimated $12,429,517 in PCMH payments.

PCMHs in Vermont are supported by **Community Health Teams (CHTs),** which are multi-disciplinary teams of dedicated health professionals in each of the state's HSAs. The CHTs support primary care providers and their patients with case management, care coordination, and screening for mental health needs, substance use, and social determinants of health (SDOH). They discuss and support patient centered goals while addressing whole person health with effective interventions that support mental and physical wellbeing. They also provide additional opportunities to support improving chronic conditions. Across the 13 HSAs, 147 FTE CHT staff members support 134 PCMHs. Payers fund the CHT staffing through PMPM payments made directly to the Administrative Entities based on attribution data provided by the Blueprint.

"Hub & Spoke" is Vermont's system of medication-assisted treatment (MAT), supporting people in recovery from opioid use disorder. Nine regional Hubs (or "opioid treatment programs") offer daily support for patients with complex addictions. At over 113 local Spoke practices called OBOT (or "office-based opioid treatment") doctors, nurses, and counselors offer ongoing opioid use disorder treatment fully integrated with general health care and wellness services. The Blueprint administers the Spoke part of the Hub & Spoke system. In 2021Q3, 295 prescribers offered MAT in Spoke settings, which is an increase from 265 in November of 2019. Of these prescribers, 83 treated ten or more individuals with opioid use disorder, a rate that has stayed constant since November 2020. Specialized Spoke staff, which include the nurses and license mental health professionals working with MAT patients in Spoke settings, included 74.67 FTE positions in 2021Q3

The overarching goal of the **Women's Health Initiative (WHI)** is to increase rates of pregnancy intention and to support the health and well-being of Vermont women. The program supports mental health, substance use, and social determinants of health screening and referral to services as well as same day access to family planning counseling and effective contraceptives in 23 Ob-Gyn and 22 PCMH practices in the state. Embedded WHI social workers act to both integrate interdisciplinary health services into Ob-Gyn specialist practices and to coordinate needed physical health, mental health, and social services on behalf of reproductive age women.

Response to COVID-19 Pandemic

In the words of St. Albans Program Manager, Denise Smith, 2021 has been a year of lessons about gratefulness, adaptability, resilience, patience, and continued persistence. Blueprint staff and partners have used the lessons learned so quickly in 2020 to further meet the needs of their communities in what has become our 'new normal'. Incorporating telehealth as appropriate, routinely keeping patients and staff physically and emotionally safe with new protocols, facilitating vaccine distribution, and attending to Vermonters' growing mental health needs were commonplace across the state in 2021. Additionally, Blueprint central office

personnel contributed substantial staff hours of support to the Agency of Human Services in planning, management, coordination, and provider surveys related to COVID-19 vaccine distribution and clinic planning throughout the state. As always, Vermonters come together when there is a need.

Blueprint Data and Analytics

Blueprint staff contributed substantial hours of support to the State's COVID-19 response, and research into specialty wait times. We report on whole-population healthcare metrics for Vermont based on claims and clinical data. Results are provided at the state-level and also broken out by hospital service areas for measures including emergency department visits, inpatient discharges, and specialist encounters. The data is as of Calendar Year 2019, the latest year for which we have such data. Finally, a summary of patient-experience survey results is provided, with trends covering CY 2017 to CY 2020. Summary statistics are presented for both the state and for individual Blueprint Health Service areas. Although trends differ by region, the results show relatively steady levels of self-reported satisfaction and access to care.

Health Service Areas (HSAs) At-a-Glance

This section highlights the work of the Blueprint facilitation infrastructure community-by-community. It shares information about what practices participate in the program and the number of FTE staff supported via the Blueprint services. It also provides a community perspective on local achievements and activities.

Conclusion

The Blueprint for Health has a long and respected history of nimbly responding to local communities with its strong support of primary care and seamless coordination with community-based organizations to meet the physical health, mental health, and social service needs of Vermonters. This local, responsive, and unwavering commitment proved to be invaluable during the onset of the 2020 COVID-19 pandemic and continued to enable providers to meet the changing care needs of all Vermonters in the 'new normal' of 2021. Blueprint central and regionally based team members, employed by many different organizations yet all moving in the same direction, work in collaboration to improve our system of care efficiently and compassionately, one person-to-person interaction at a time.

Looking Forward: Program Evolution and Expansion

As Vermont treads the path to recovery from the COVID-19 global health pandemic, access to health care and human services is a top priority for the Agency of Human Services and the Blueprint for Health.

Preventive and necessary services have been deferred by Vermonters due to pandemic isolation, workforce availability, and new demands on the system. Further, need for mental health and substance use disorder care has grown significantly from pre-pandemic levels.

Evolution and expansion of Blueprint for Health must be driven by the principle of increasing access to health and human services for Vermonters. Program expansion and evolution should support improving access to care and services for Vermonters specifically for: primary care, care coordination services, and mental health and substance use disorder services.

Primary Care

- The Blueprint for Health will conduct a system assessment on primary care access taking into consideration how the pandemic impacted access to primary care. The assessment will determine which practices are open to new patients, whether established patients can see their providers when need arises and whether Vermonters are receiving health care services in the most appropriate settings. Based on this assessment, the Blueprint will utilize the quality improvement facilitator network to develop a primary care access learning collaborative and to support best practices for referral to specialty care. The program will also focus on developing an implementation plan for improving primary and specialty care integration. Underpinning the assessment will be an evaluation of state level performance relative to existing Primary Care Medical Home (PCMH) standards and the identification of future focus areas to promote health equity within the PCMH model.

Care Coordination Services

- In partnership with the Agency of Human Services Field Services and the Vermont Chronic Care Initiative (VCCI) the Blueprint for Health will participate to identify gaps in care management and care coordination and assess opportunities for more seamless coordination.

Mental Health and Substance Use Disorder Services

- Building on the successful Hub and Spoke model for Medication Assisted Treatment (MAT) the Blueprint will focus on expanding and standardizing the Spoke model of care across all payer types with initial focus on commercial payer participation in spoke model of care. The Blueprint program will also work to address spoke quality and performance as more "spoke only" providers integrate into Hub and Spoke model. Further, the Blueprint will consider opportunities to adapt the Hub and Spoke treatment model to support care for poly-substance dependency and to support further integration with mental health care.

- To support expanded access to integrated primary care and mental health and substance use disorder treatment, the Blueprint will develop a path to expand the Women's Health Initiative model of screening and referral to social supports and mental health and substance use disorder treatment, to all Blueprint practices.

Multi-disciplinary Community Health Teams (CHT) are essential to each objective stated above. The Blueprint will evaluate the additional supports that may be required to promote the expansion of CHTs.

Longer-Term Goals and Role for Blueprint for Health in Payment and Delivery System Reform and Redesign

- The Blueprint for Health serves as the foundation for integrated preventive care and for complex care coordination, both of which are central and necessary activities to maintain and expand in a value-based reimbursement model for health and human services. Further, the Blueprint for Health serves an essential role in convening quality improvement activities to support planning, design, and implementation of delivery system improvements. As the State of Vermont explores new approaches to an All-Payer Model for value-based reimbursement, the Blueprint for Health program and infrastructure will be critical considerations, including potential additional expansion and evolution of the program, both in structure and role in delivery system redesign.

Introduction

The Vermont Blueprint for Health (Blueprint) was established to promote high quality primary care that is integrated with services outside of the medical setting that affect health and wellbeing. Supported by multi-payer participation, the Blueprint has built a foundation of primary care based on the patient-centered medical home (PCMH) model and bolstered by multi-disciplinary Community Health Teams (CHTs) that provide care coordination and linkages to services across the care continuum. Essential to the success of the PCMHs and CHTs is a network of locally hired Program Managers, Community Health Team Leaders, and Quality Improvement Facilitators. This network has been integral to facilitating local transformations and increasing collaboration across community partners.

Building on the PCMH and CHT model, the Blueprint program has expanded to include the Hub and Spoke System of Care for individuals with opioid use disorder (OUD) and specifically supports primary care practices providing medication-assisted treatment (MAT). The Blueprint also created the Women's Health Initiative to ensure access to services that support pregnancy intention.

While the program has evolved beyond the original "chronic care management plan" described in legislation, it remains true to the original vision of all-payer supported, community-directed health reform that promotes the health of all Vermonters. The Blueprint is a demonstrated leader in establishing a statewide network of PCMHs supported by CHTs focused on integrating care and services. The Blueprint model adds a per-member per-month payment for coordinating primary care services and improving quality and value performance on top of existing fee-for-service payments. Building on the Blueprint's foundation, Vermont's All-Payer Accountable Care Organization (ACO) Model advances additional payment and delivery system reform initiatives to move the state more aggressively away from fee-for-service. To accelerate the Blueprint's complementary function with large scale payment reform, the Blueprint for Health has been relocated within the Office of Health Reform in the Secretary's Office at the Agency of Human Services along with the Health Information Exchange initiative, allowing for greater coordination with the Agency of Human Services' field teams and the Vermont Chronic Care Initiative.

Community-Based Facilitation of Health Reform

The Blueprint provides support to practices and communities to facilitate the implementation of health care reforms, such as gaining recognition as PCMHs, improving communication and coordination across health and social services in a community, and using data to address quality improvement initiatives. The approach to reform that the Blueprint has taken incorporates changes in service delivery, changes in how payments are made - ideally aligned across payers, and support for providers and communities in implementing these changes. This last element, which incorporates a process of co-design with local health systems has proven highly effective in enduring reforms.

The network of local health reform leaders, which includes Blueprint Program Managers, Quality Improvement Facilitators, and Community Health Team Leaders, is one element that has differentiated the Blueprint's approach from other health care reform efforts. This network is essential to the Blueprint's objective of continuously strengthening local health systems to provide care coordination, advance population health goals, and manage cost risks arising from shifts to value-based payments. For example, the network supports all participating practices in the community as well as the CHTs in efforts such as initiating and sustaining workflow changes, quality improvement efforts, and connections across community networks. This approach has allowed the Blueprint to move beyond "care management" and focus on the integration of physical health care, social services, mental health care, and substance use disorder treatment services to meet the holistic needs of all Vermonters.

The positions in this network are supported through the Blueprint's Global Commitment to Health-funded grants made to the local Administrative Entities, which are either the local hospital or FQHC. In addition to funding this network, the Blueprint provides participants with oversight, coaching, educational offerings, and peer-to-peer learning opportunities. This system of Program Managers, Quality Improvement Facilitators, and Community Health Team leaders is the foundation upon which other evolving health reforms are built, with payments to local systems resulting in staffing on the ground to accomplish reform goals.

Administrative Entities

The Blueprint has established a single Administrative Entity in each of the 13 Health Service Areas (HSAs) at either the local hospital or Federally Qualified Health Center (FQHC). Through these entities flow Blueprint funding, such as Blueprint grants and CHT payments, and state-level strategic directions for implementing health care initiatives at the local level. Specifically, their work includes local program leadership, financial management, and staffing of CHTs. The Administrative Entities also hire the Program Managers, who lead implementation and engage community partners at the local level. Community Partners may include home health agencies, mental health agencies, developmental disability service providers, emergency medical service providers, adult day service providers, area agencies on aging, transportation services, foodbanks, and community action agencies. These same Administrative Entities are all ACO participants, so these leaders work on behalf of both the Blueprint and the ACO. Furthermore, each Administrative Entity contributes their own financial and human resources, beyond the scope of their Blueprint grants, demonstrating their commitment to primary care and improved population health. In turn, the Blueprint's grants help support local systems of care.

Blueprint Program Managers

Blueprint Program Managers provide leadership in each community to coordinate healthcare delivery system improvement efforts. While they are employed by the hospital or FQHC in the HSA, they help organize, lead, and staff collaborative initiatives with the ACO, local human service agencies, health departments, specialty care providers, mental health providers, and primary care providers to facilitate the integration of services. They are responsible for contacting all primary care practices within their HSA to encourage, engage, and support practice participation in the Blueprint and other health system reform activities. Additionally, Program Managers are responsible for administering funds and staffing plans for the local CHTs on behalf of all participating payers, including core CHT, Spoke staff, and WHI staff. Program Managers set up the systems through which integrated services can be delivered in the community.

Blueprint Quality Improvement Facilitators

In addition to Program Managers, the Blueprint supports participating practices with a quality improvement coach, called a Quality Improvement (QI) Facilitator. QI Facilitators support practices with Blueprint-generated all-payer data on practice performance and their own training and expertise in process improvement methodologies (such as Clinical Microsystems, Model for Improvement, and Lean process improvement). Quality Improvement Facilitators initially help primary care practices to secure National Committee for Quality Assurance (NCQA) PCMH recognition. After recognition is achieved, the facilitators regularly return to help with quality improvement efforts related to panel management and outreach, care coordination, promotion of individual health and wellness, chronic condition management, and ongoing practice transformation in alignment with State-led health care reform priorities. These priorities include:

- focusing quality improvement activities on All-Payer ACO Model and ACO quality measures
- promoting team-based care
- implementation of Blueprint and other health care reform initiatives (e.g., Spoke program, Women's Health Initiative, improving opioid prescribing patterns)

- prevention and management of chronic conditions (e.g., for diabetes and hypertension through connections with learning collaboratives, self-management programs, health coaches, registered dieticians, and care management).

Blueprint for Health Services

Patient-Centered Medical Home Program

The original development of the Blueprint program was based on the observation that effective health systems have strong, well-funded, primary care services. The program was first authorized as a pilot in 2008 and as a statewide program in 2010 by the Legislature to support the transformation of primary care services in Vermont as a foundational first step in health system reform. While the Blueprint program highly values local innovation, it also equally weights the use of national standards to drive improvements in primary care delivery, quality, and payment. To this end, the State of Vermont uses NCQA standards for recognizing Patient-Centered Medical Homes (PCMH). The PCMH model supports care that is patient-centered, team-based, comprehensive, coordinated, accessible, and focused on quality and safety. The model also promotes care that is provided when and where the patient needs it, and in a way that the patient understands. Additionally, these standards require that measures be based on the practice's entire patient panel, not only those patients attributed to an ACO or to any single payer.

Almost all of Vermont's primary care practices participate in the Blueprint program, and these 134 PCMHs currently serve 304,526 insurer-attributed patients. Attribution to a practice is determined by the practice at which the patient has received most of their primary care within the 24 months prior to the date the attribution process is conducted. Payers, including Medicare, Medicaid, and major commercial payers in Vermont, make per member per month (PMPM) payments directly to practices based on the number of the payer's patients attributed to each practice. In 2021, the 134 primary care practices (or their parent organizations) collectively received an estimated $12,429,517 in PCMH payments.

2021 Program Updates

In response to the COVID-19 pandemic and recognizing the difficulties practices experienced during the early days of the pandemic in 2020, NCQA adjusted deadlines in 2020. However, annual reporting deadlines reverted to previous dates for most practices in 2021, and because of these date changes many practices had less time to complete QI activities. Nonetheless they were successful in this endeavor. The QI facilitators noted that to their knowledge all practices successfully maintained recognition, a great feat given all the other pressures of 2021.

Community Health Teams

PCMHs in Vermont are supported by Community Health Teams (CHTs), which are multi-disciplinary teams of dedicated health professionals in each of the state's HSAs. These teams provide supplemental services that allow Blueprint-participating primary care practices to focus on promoting prevention, wellness, individual and team care. The CHTs support primary care providers in identifying confounding causes of health problems, including screening for mental health needs, substance use, and social determinants of health (SDOH). They discuss and support patient centered goals while addressing whole person health with effective interventions that support mental and physical wellbeing. They also provide additional opportunities to support improving chronic conditions. Across the 13 HSAs, 147 FTE CHT staff members support 134 PCMHs. Payers fund the CHT staffing through PMPM payments made directly to the Administrative Entities based on attribution data provided by the Blueprint. 'Core' CHT services include:

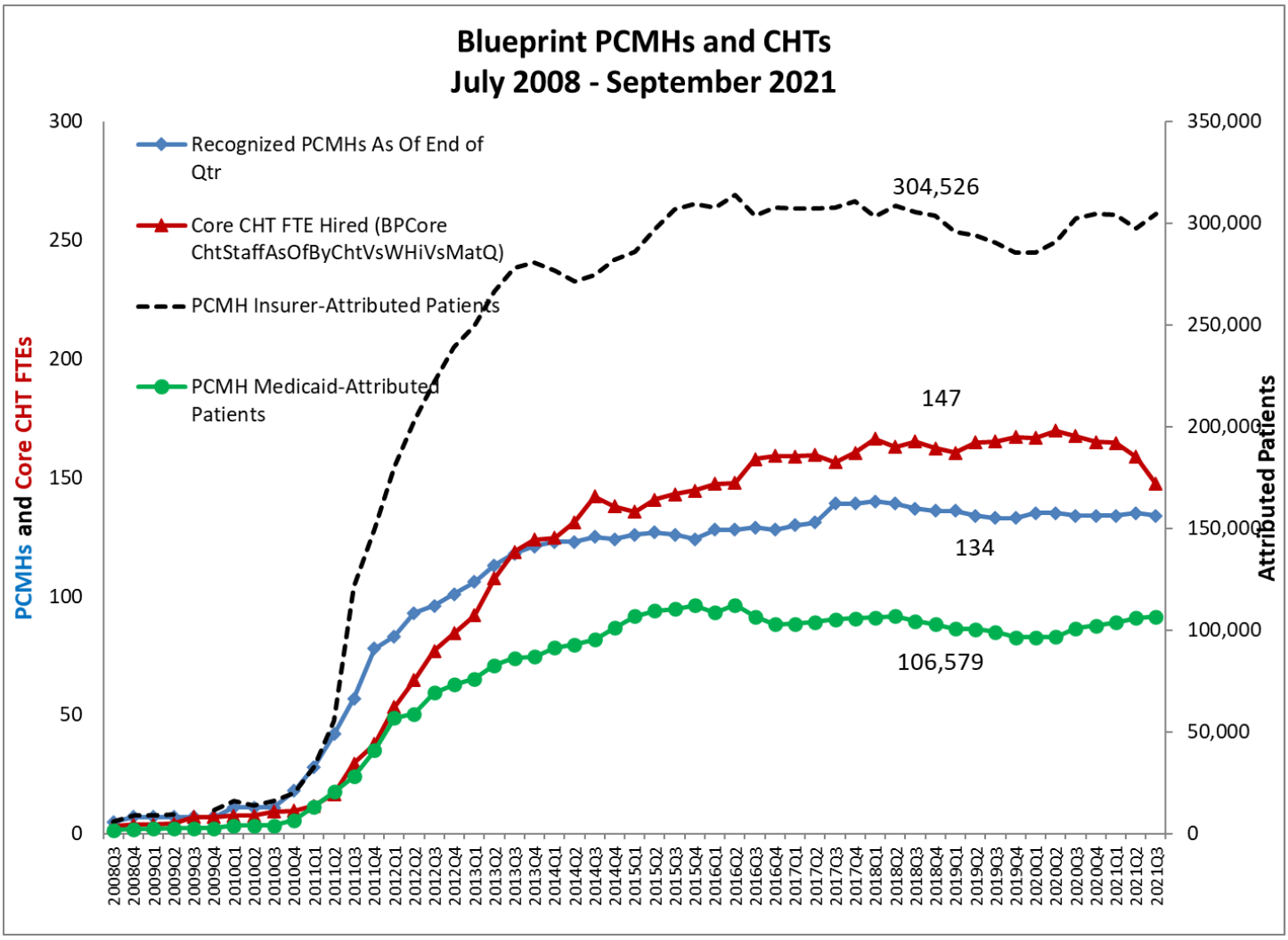
- Screening
- Individual care coordination and team care conferences
- Brief interventions that could include short term counseling
- Referrals and navigation to services that could include self-management courses
- Condition-specific wellness education
- Nutrition services

- Connecting to peer support

CHT services may be co-located with the practices (also known as 'embedded') or centralized in the HSA and shared across multiple practices. Actual service configuration, staffing, and location are determined by local leaders based on community demographics and health needs, identified gaps in available services, and the strengths of local partners. Funded by Medicaid, Medicare, and major commercial insurers, access to local CHTs is offered barrier-free to patients and practices. This means no co-payments, no prior authorizations, and no billing. Further, these services are available regardless of whether the individual is attributed to the ACO. Vermont's payers that include Medicaid, Medicare, BlueCross BlueShield of Vermont, MVP and Cigna all make direct payments to the Administrative Entities to pay for the CHT staff. In 2021 these payments amounted to $9,381,138 to fund CHT staff capacity

CHTs serve as the foundation for the ACO's care coordination activities on the ground. The majority of outpatient care coordinators in Vermont are Blueprint-funded CHT staff who manage care and services for ACO-attributed patients as well as those who are not attributed to the ACO. The importance of the CHT in the ultimate success of the ACO model in Vermont makes the Blueprint program a critical partner in the All-Payer ACO Model implementation. The final section of this report, HSAs At-a-Glance, offers a portrait of the ACO staffing and activities that are either directly funded or leveraged by the Blueprint payment and support services reforms.

Figure 1: Blueprint PCMHs and CHTs



Hub & Spoke Program

"Hub & Spoke" is Vermont's system of medication-assisted treatment (MAT), supporting people in recovery from opioid use disorder. Nine regional Hubs (or "opioid treatment programs") offer daily support for patients with complex addictions. At over 113 local Spoke practices called OBOT (or "office-based opioid treatment") doctors, nurses, and counselors offer ongoing opioid use disorder treatment fully integrated with general health care and wellness services. The Blueprint administers the Spoke part of the Hub & Spoke system.

Spokes are settings where opioid use disorder (OUD) treatment is integrated into general medical care, like treatment for other chronic diseases. These settings are mostly primary care or family medicine practices and may also include obstetrics and gynecology practices, specialty outpatient addictions treatment programs, and practices specializing in chronic pain. Prescribers in Spoke practices are physicians, nurse practitioners, and physician assistants who are federally waivered to prescribe buprenorphine. They may also provide oral naltrexone or injectable Vivitrol. Spokes receive specialized staff – one nurse and one licensed mental health/addictions counselor for every 100 Medicaid patients receiving medication-assisted treatment (MAT). Like the core CHT staff in primary care, the Spoke staffing helps expand access to treatment by supporting prescribers with multi-disciplinary teams to see patients more frequently, proactively monitor care, and coordinate patient care across health and human service systems. For patients, specialized Spoke staff are essential members of their care team; they work together towards long-term recovery and improved health and well-being. The Blueprint and the Vermont Department of Health's (VDH) Division of Alcohol and Drug Abuse Programs (ADAP) offer ongoing training to Spoke prescribers and teams. More detail about the structure and impact of the Hub & Spoke System can be found on the Blueprint website.

In collaboration with communities statewide, ADAP continued to implement Rapid Access Treatment (RAM) for Opioid Use Disorder. The statewide expansion includes 10 hospital emergency departments starting individuals with OUD on medication with a warm handoff to a designated outpatient treatment provider from our Hub and Spoke system.

2021 Program Updates

VDH, DVHA and the Blueprint have been longstanding partners in working to improve the services for and health of Vermonters with substance use disorders.

The Learning Collaborative series, a more than five-year partnership between Blueprint and VDH, has brought Vermont's Hub and Spoke providers, partners, champions, and provider leaders together to share expertise and continue to improve the quality of care in the system.

The ongoing collaboration between VDH and DVHA's Pharmacy, Clinical and Transportation Units allowed the Hub and Spoke system to navigate staffing challenges across Medicaid providers and programs as well as to enact programming changes to reduce COVID-19 risks and to respond to COVID-19 outbreaks in communities.

The Blueprint contract with Dartmouth College for MAT Learning Collaboratives provided to the Hub & Spoke Opioid Use Disorder care network was renewed in June 2021 running through June of 2022. The curriculum calendar for these events ran from January 2021 through October 2021 and will resume in January 2022 through October 2022. Five webinars, four virtual workshops, and a virtual conference were held from January through October of 2021. Sessions alternated between didactic webinars related to medication management and virtual workshops related to comprehensive care management. Four webinars were paired with four workshops on thematically related content. Topics addressed management of alcohol use disorder and other substance use disorders, long-term MAT management, mental illness and MAT continuing OUD symptoms in MAT. A fifth webinar was held in September on developing consensus within MAT care teams. The two-day October conference consisted of presentations and panel discussions on improving engagement among people with OUD in MAT and developing awareness of and responsiveness to MAT health care inequities. Average participant attendance at these ten event dates was 85 professionals. These nine events on average were rated as being very relevant to their work by 86% of respondent, and an average of 87% of respondents rated

presenters as demonstrating topic understanding very well. Video recordings and slides for these events are or will be made available for viewing on the Vermont Health Learn website.

The Blueprint continued to be a member in team meetings with commercial payers who continue to assess and design payment approaches that would support Spoke nurses and licensed counselors similar to the Medicaid-funded model. BCBSVT and MVP implemented pilot approaches in 2019-2021. Process improvement for these payment pilots is ongoing as BCBSVT and MVP continue identifying the best approaches to scale these pilots up to include more Spoke sites.

DVHA, through the Blueprint, has developed a study design in close partnership with the Department of Corrections (DOC) to evaluate continuity of MAT care for people returning to the community after incarceration. The memorandum of understanding that builds on the previous data sharing agreement between DVHA and DOC has been approved, and preliminary results are being analyzed. A complete report on the rates of continuity of care will be forthcoming in 2021.

In 2020, in conjunction with ADAP, the Blueprint began working on a three-year pilot project with Yale University that aims to improve the frequency of HIV/HCV screenings and follow-up within the Hub & Spoke network. The initial implementation phase of the pilot with the first round of Hub & Spoke practices will began early 2021. The Vermont Prescription Monitoring System may be a source of deidentified data that will add to the analysis and evaluation.

COVID-19 Response

Vermont's Hub and Spoke providers were challenged by the COVID-19 pandemic in several ways. Many in-person treatment services transitioned to telemedicine to prevent staff and client exposure to COVID-19. For necessary in-person services, people had to maintain social distancing and use appropriate personal protective equipment (PPE), both of which can impact the dynamics of treatment. Throughout the pandemic, Vermont's Hub and Spoke providers were able to maintain access to life saving treatment at all times. At no point did our Hub and Spoke providers have to shut their doors to Vermonters in need of care. DVHA increased the allowable buprenorphine supply from 14 days to 30 days for Vermont Medicaid members, reducing the number of times people had to be seen in person in our Spoke providers

In 2020, Vermont received a $2 million SAMHSA federal emergency grant to make sure people with mental health and substance use disorders can access care during the COVID-19 pandemic. This grant is allowing all Hubs to provide delivery of take-home medications and curbside dosing to ensure people receiving MAT can continue to do so without disruption during the pandemic, even if they need to isolate or quarantine due to COVID-19 exposure or infection.

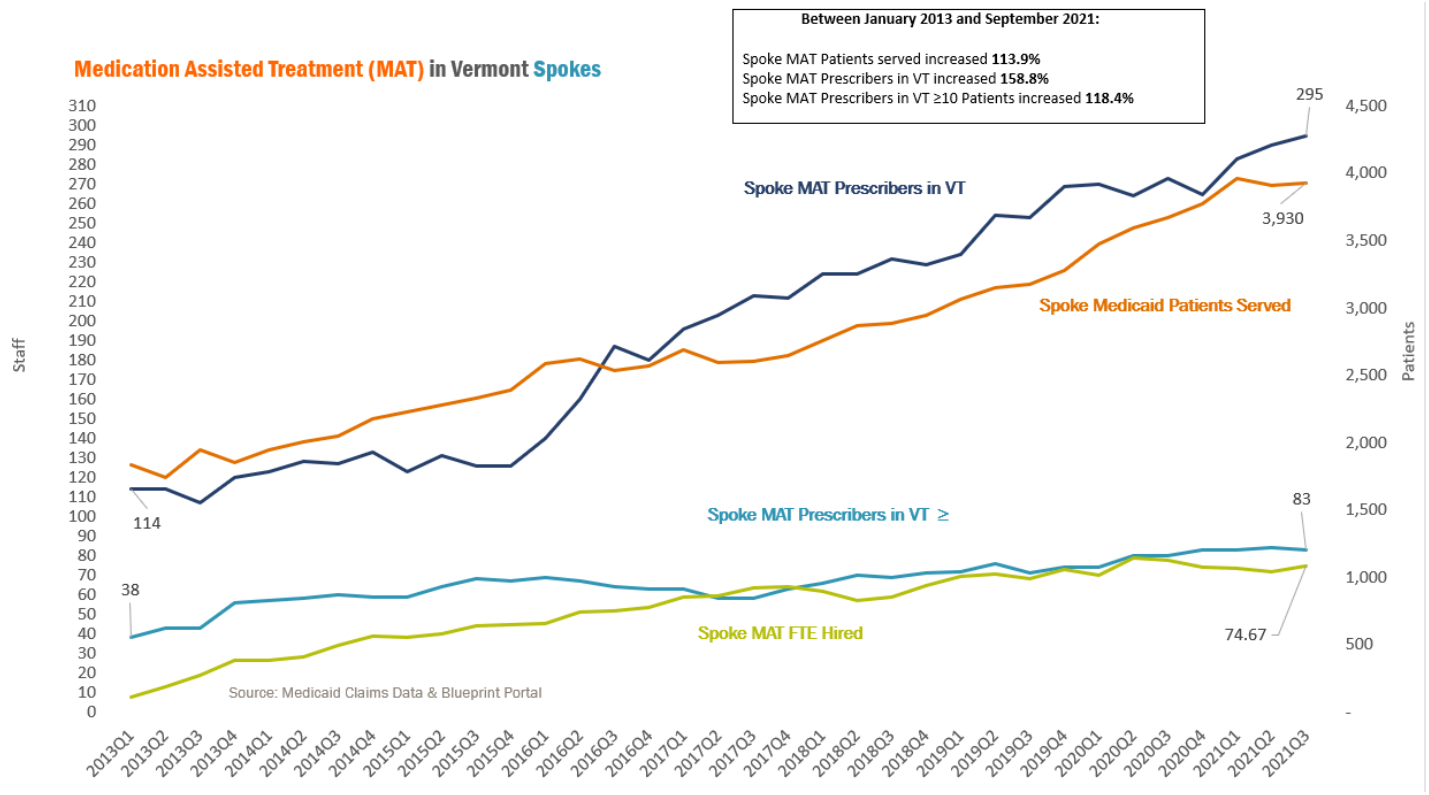
People in our Hub and Spoke system stayed in treatment through the pandemic and the total number of Medicaid members receiving MAT in our Hub and Spoke system increased 2% between 2019 and 2020.

With the flexibilities afforded by our federal partners in response to the ongoing risks of COVID-19 exposure and infection and the continued risk presented by substance use disorder, VDH, DVHA, and the Blueprint worked with a number of new provider entities looking to expand into Vermont through tele and in-person services for individuals with substance use disorder. The state partners worked together to ensure that these new providers became integrated into Vermont's system of care, complimenting existing services and providers and enhancing the existing opportunities for people to access and engage with treatment.

When the Hub & Spoke system of care launched in 2012, Spoke sites were serving approximately 2,500 patients. As seen in Figure 2 below, the overall MAT population has steadily increased in Vermont since the implementation of Hub & Spoke, resulting in the consistent growth and ongoing need, both of MAT and its wraparound Spoke services. Figure 2 below also shows the growth of the Spoke program, including the number of providers, Spoke staff, and patients. The number of Medicaid beneficiaries receiving treatment in Spoke settings grew from 3,744 in November of 2020 to 3,930 at the end of 2021Q3. In 2021Q3, 295 prescribers offered MAT in Spoke settings, which is an increase from 265 in November of 2019. Of these prescribers, 83

treated ten or more individuals with opioid use disorder, a rate that has stayed constant since November 2020. Specialized Spoke staff, which include the nurses and license mental health professionals working with MAT patients in Spoke settings, included 74.67 FTE positions in 2021Q3

Figure 2: Count of Spoke MAT patients and prescribers through September 2021



Women's Health Initiative

The Women's Health Initiative (WHI) strives to support any persons who can become pregnant in their efforts to experience healthy pregnancies, avoid unintended pregnancies, and build thriving families. The WHI provides increased mental health and social service staffing at specialty practices and utilizes the existing CHT at Blueprint PCMH practices. If a patient identifies as at-risk, they have immediate access to a WHI mental health clinician for brief interventions, counseling, and navigation to community-based services and treatment as needed.

The Blueprint partners with participating women's specialty providers and PCMH primary care practices to support patients of child-bearing age. WHI providers engage with patients at new patient and annual visits to screen for mental health needs, substance use, and SDOH. They ask about pregnancy intention for the coming year using the One Key Question®, which asks if, when, and under what circumstances a woman would like to become pregnant. Women with a desire to become pregnant receive services to support a healthy pregnancy. If the woman would like to prevent pregnancy, providers conduct comprehensive family planning counseling and provide patients with options for most and moderately effective contraception, which could include access to same day long-acting reversible contraceptives (LARC) if clinically indicated.

Comprehensive screening includes questions about SDOH needs of food/housing insecurity, interpersonal violence, depression, anxiety, harm to self or others, in addition to screening for mental health needs and substance use. Positive screens are addressed with referrals to services, and brief interventions and treatment may be provided by the WHI-supported mental health clinician if indicated. WHI clinicians develop mutual referral agreements with community partners to help establish meaningful relationships to support patients.

2021 Program Updates

WHI practices can access the program's central WHI Quality Improvement (QI) Facilitator to ensure the goals of the program are being met. In 2021, the QI Facilitator and WHI Program Lead met regularly with representatives from all WHI practices to identify process improvement opportunities, ensure the program elements are in place, and support improved patient experience of care.

The Blueprint provided several trainings for practices that included best practices for comprehensive family planning counseling and 'lunch and learns' on same-day LARC insertion.

Additional information about the Women's Health Initiative, including research supporting WHI goals and strategies and payments that support the work, can be found on the Blueprint for Health website.

Figure 3 below shows WHI enrollment and staffing over time. In 2021, the number of PCMHs enrolled in the WHI increased, leading to more primary care practices conducting comprehensive SDOH screenings, initiating brief interventions and referrals to services when a need is indicated by a positive screen, providing comprehensive family planning, and offering most and moderately effective contraception.

Figure 3: Count of WHI Practices, CHT Staff, and Patients

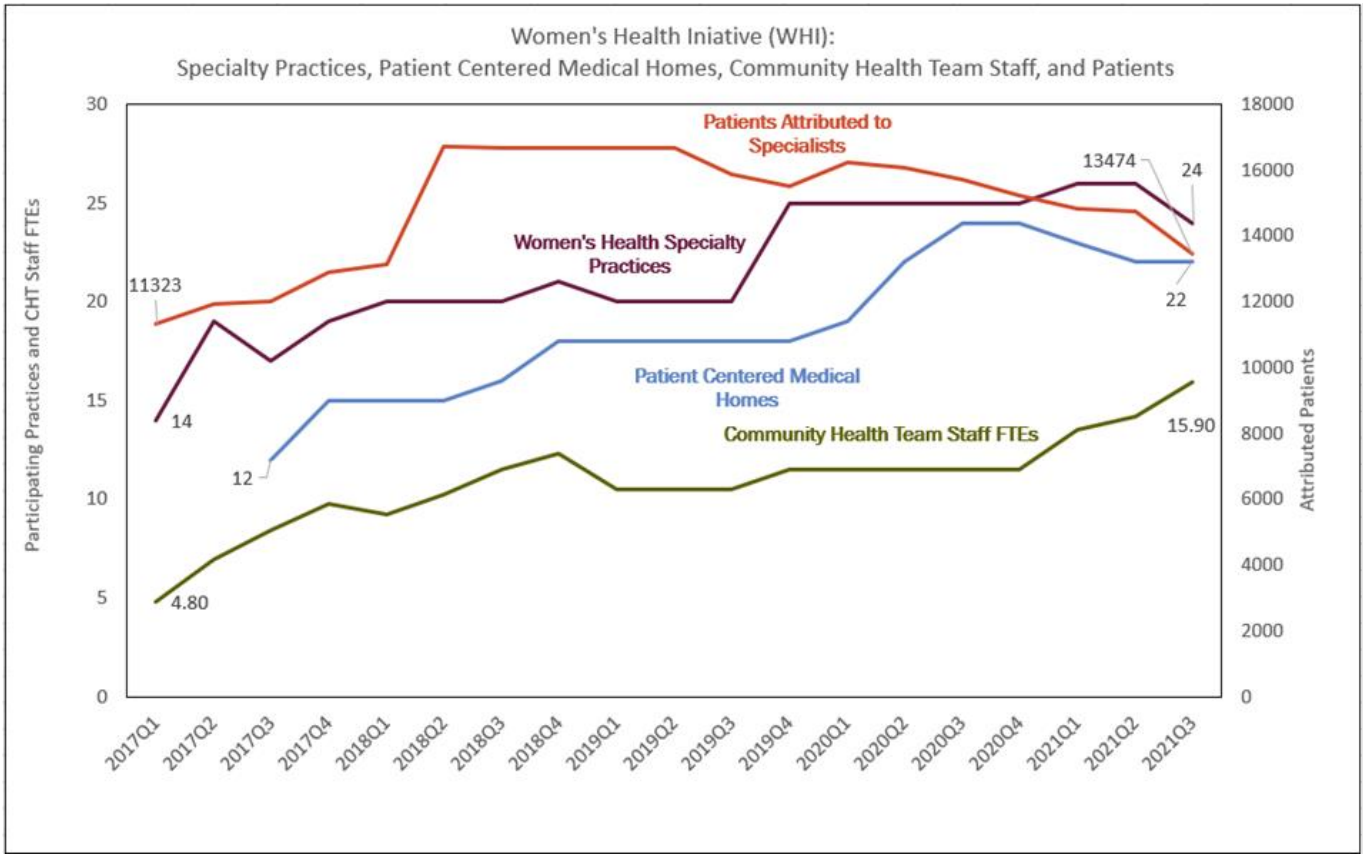


Figure 4: WHI practices and attributed Medicaid beneficiaries by Health Service Area

Health Service Area	WHI Specialist Practices as of 10/1/2021	WHI PCMH Practices as of 10/1/2021	WHI CHT Staff FTE Hired as of 10/1/2021	WHI Specialist Quarterly Attributed** Medicaid Beneficiaries as of 10/1/2021	WHI PCMH Quarterly Attributed** Medicaid Beneficiaries as of 10/1/2021
Barre	1	1	1.5	636	204
Bennington	1	2	0.50	933	268
Brattleboro	1	0	0.6	899	0
Burlington	2	9	2	2,580	4,864
Middlebury	1	0	0.75	646	0
Morrisville	1	3	0.50	325	1,401
Newport	1	0	1	903	0
Randolph	2	0	0.5	484	0
Rutland	2	0	3	1,395	0
Springfield	0	5	0	0	1,744
St. Albans*	0	0	0	0	0
St. Johnsbury	1	2	0.75	873	829
Windsor*	0	0	0	0	0
Planned Parenthood (Statewide)	12	0	4.8	4,157	0
Total	**24**	**22**	**15.9**	**13,474**	**9,310**

*The St. Albans and Windsor Health Service Areas do not have WHI practices

**Quarterly attributed patient counts at the HSA level have a small amount of overlap due to patients moving across HSAs in different months. The statewide quarterly total is deduplicated.

***The PPNNE practice in Rutland is included in both the WHI Specialist field for Rutland and in the PPNNE statewide field. Patients are attributed to the Rutland HSA. Total WHI Specialist practice count is deduplicated.

Self-Management Programs

For many years, the Blueprint offered workshops that help people learn skills to better manage chronic conditions. Topics include healthy living with diabetes, diabetes prevention, tobacco cessation, mental health and emotional well-being, and living with chronic pain. Participants gain a better understanding of their health condition, explore their motivations, identify their strengths, and develop plans for achieving their health goals. They begin putting those plans into action with support from coaches and peers, and the workshops last

from four weeks to 12 months. The Self-Management programs are also supported by the Vermont Department of Health, which supports the training of program leaders and marketing to potential participants.

2021 Program Updates

In 2020, the Blueprint closely reviewed the programs offered and how they were administered and found that the programming was no longer achieving the same results as when they were introduced in 2008. While many workshops have successful outcomes, the number of participants has been declining over time and finding and maintaining workshop leaders has been difficult. Furthermore, providers are often reluctant to refer to workshops that may be waiting for an adequate number of participants before being scheduled. The Blueprint has also received feedback that many individuals are more interested in individualized offerings to improving health. Transportation, childcare, and work schedules were often barriers to in-person participation.

In 2021, the Blueprint worked with self-management stakeholders to determine the most advantageous method for delivering and overseeing these programs. The Agency for Human Services determined that the Department of Health, as a key stakeholder and a recipient of CDC grant funding to address diabetes and hypertension, could better provide day-to-day support for the Self-Management Programming. The Blueprint continued to administer the programming through September 30, 2021. On October 1, 2021, the Blueprint and the Department of Health entered into a Memorandum of Understanding, whereby the Blueprint will provide Self-Management funds to VDH. The Blueprint, as a funder of this activity, will remain closely aligned with VDH as they move to streamline and modernize the Self-Management Programming. The Blueprint and the Department of Health will continue to evaluate the administration of Self-Management Programs during the coming year.

Collaboration with OneCare Vermont Accountable Care Organization (ACO)

In 2021, Ena Backus, AHS Director of Health Care Reform, and Sara Barry, Chief Operating Officer of OneCare Vermont, met with each Health Service Area to discuss the strengths and challenges of the current ACO and APM collaborations. Several themes emerged across the Health Service Areas:

- Community Health Teams serve as the foundation for the ACO's care coordination activities on the ground. The majority of outpatient care coordinators in Vermont are Blueprint-funded CHT staff who manage care and services for ACO-attributed patients as well as those who are not attributed to the ACO.
- Office of Health Care Reform will continue to increase communication and coordinate messaging with OneCare regarding goals.
- OneCare Quality Improvement staff should work closely with the Blueprint network of Quality Improvement facilitators to align measures, such as those required for PCMH recognition and OneCare targets.
- The Blueprint and OneCare should focus on data alignment and providing "real-time" data.
- The ability to access data should be flexible and easier to access and use.
- The OneCare payment structure has changed several times and the field would like more predictably, similar to the Blueprint payment structure.

Regarding care coordination, the Blueprint CHT staff and leadership discussed appreciation for the OneCare sponsored Certified Case Manager (CCM) training but would like further understanding of the future of the model and questioned whether OneCare and/or the Blueprint will support ongoing funding. Care Navigator, OneCare's software platform used as a universal tool for care coordination, will not be used for payment in 2022, as feedback from CHT staff and leadership indicated that the required 'double documentation' is an inefficient use of resources. Furthermore, other community partners have not been able to implement Care Navigator in full and so the tool has not been as effective as hoped. The Blueprint would like to continue looking into how HSAs can measure the impact of care coordination.

Future Direction

AHS recruited Dr. John Saroyan to be the new Blueprint for Health Executive Director in December 2021. He began shortly thereafter on January 3, 2022. Dr Saroyan began serving Vermonters in March of 2013 when he became the Hospice Medical Director at Bayada Home Health Care in Vermont and New Hampshire.

Dr. Saroyan has evaluated and treated hundreds of terminally ill people in their homes. He has developed strong relationships with primary care providers, hospitalists, sub-specialists, hospital administrators, nursing home and assisted living staff leadership, as well as Bayada's own team of hospice providers, nurses, social workers, home health aides, and chaplains.

"While I have devoted my entire professional career thus far to alleviating the pain and suffering of chronically and terminally ill individuals, I feel the time is now to turn my experience and knowledge more broadly to prevention, health promotion, and complex care management so that Vermonters may live longer, healthier lives," said Dr. Saroyan. "I also want to help ensure that our health care practitioners and staff will be there to serve them. Blueprint for Health is an established agent of health care systems improvement and reform that I am honored to have to the privilege of leading."

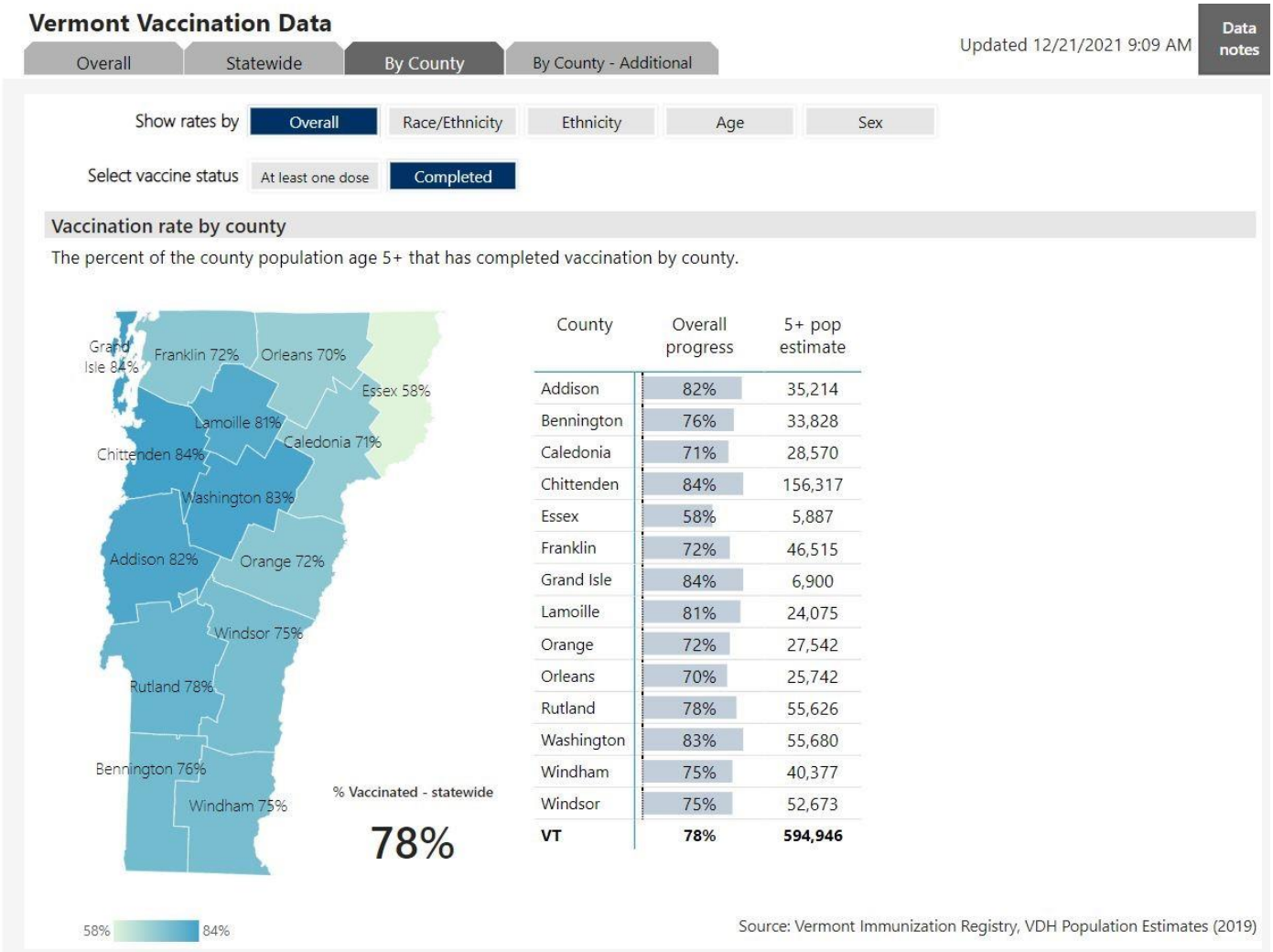
Blueprint's central and field staff welcomed Dr. Saroyan into his new role along with the AHS Commissioners and Secretary. He is actively developing a strategic plan for staffing and programmatic updates and development with the Director of Health Care Reform, Ena Backus, and Interim Secretary Samuelson.

Blueprint Data and Analytics

COVID-19 Response Support

Over the course of CY 2021, Blueprint central office personnel contributed to the Agency of Human Services in planning, management, coordination, and provider surveys related to COVID-19 vaccine distribution and clinic planning throughout the state. This work by the State of Vermont has resulted in relatively high vaccination completion rates throughout the state, as shown in the figure below.

Figure 5: ***COVID-19 Vaccination Rates by County, As of December 21, 2021 (Completed Base Vaccinations)***



County	Overall progress	5+ pop estimate
Addison	82%	35,214
Bennington	76%	33,828
Caledonia	71%	28,570
Chittenden	84%	156,317
Essex	58%	5,887
Franklin	72%	46,515
Grand Isle	84%	6,900
Lamoille	81%	24,075
Orange	72%	27,542
Orleans	70%	25,742
Rutland	78%	55,626
Washington	83%	55,680
Windham	75%	40,377
Windsor	75%	52,673
VT	**78%**	**594,946**

Blueprint Evaluation: Healthcare Measurement Results for Blueprint Target Populations

Healthcare Claims and Clinical Data

Since its inception, a core mission and statutory responsibility of the Blueprint has been to support service delivery reform and evaluate quality and cost outcomes through analysis of multi-payer claims and clinical data. For analysis of multi-payer populations (given the Blueprint's statutory multi-payer responsibilities), the Blueprint partnered with the Green Mountain Care Board (GMCB) to add Blueprint evaluation work to the GMCB's existing all-payer analytics contract. Calendar Year (CY) 2019 is the latest year for which we have multi-payer, population-level, healthcare measurement data for Vermont, and it represents the last baseline year of healthcare service outcomes prior to the disruptions of the COVID-19 pandemic. The following annual healthcare evaluation measures were calculated by Onpoint Health Data, under contract with the GMCB and Blueprint program. Claims-based measurement results are derived from the Vermont Health Care Uniform Reporting and Evaluation System (VHCURES), Vermont's all-payer claims dataset (APCD) managed by the GMCB, and clinical/hybrid measures used records from the Blueprint's Vermont Clinical Registry (VCR), which was discontinued at the end of CY 2019 in anticipation of new clinical data resources under development at Vermont Information Technology Leaders (VITL). Blueprint practice and provider registry information used for primary-care patient attribution was derived from the Blueprint's own web portal database. Further details related to the Blueprint CY 2019 community health profile measures are posted on the Blueprint for Health website at https://blueprintforhealth.vermont.gov/community-health-profiles.

Populations of Analysis

In CY 2019, 68.4% of VHCURES members were served by Blueprint Patient-Centered Medical Homes (PCMHs). Because of this large degree of overlap, measurement results for the total VHCURES population and for the PCMH-attributed population are generally similar and, consistent with our annual reports of prior years, we present here measurement results for the wider primary-care service target population of VHCURES members (i.e., individuals enrolled as in a health plan reporting to VHCURES), minus a small number of exceptions. This represents a multi-payer member sample, independent of primary-care attribution and independent of Accountable Care Organization (ACO) attribution. In 2019, this VHCURES data represented 424,700 people, or 68.1% of Vermont's 2019 population.

As in prior Blueprint annual reports, this report attempts to address the significant shift in the VHCURES data due to the 2016 *Gobeille vs. Liberty Mutual Insurance Company* U.S. Supreme Court decision. This decision allowed health care plans falling under ERISA authority to opt out of submitting data to all-payer claims databases, resulting in many of these plans ceasing to submit data to VHCURES. The remaining population represented in VHCURES tended to be older and sicker resulting in higher average per member per year (PMPY) costs and utilization rates relative to previous years. To address this change and allow comparability with earlier years the Blueprint removed claims associated with self-insured plans no longer submitting after 2016 from all previous years. Analysis indicated that this step achieved greater consistency in age, payer mix, health status, and gender across all years.

In addition to data from self-insured plans no longer submitting, this analysis excludes data from ages less than one year of age due to frequent challenges in separating their claims from their parents' claims during this period, and from ages 65 and older for whom commercial or Medicaid is the primary payer due to difficulties in identifying total cost of care across multiple payers. VHCURES data also does not include federal employees, members of the military, veterans, and people who are uninsured.

Even with these limitations in the data, the following analyses represent healthcare outcomes for the majority of Vermont residents.

Figure 6: Population Counts and Demographics

Statewide Demographics	CY 2019	CY 2019
U.S. Census Population Estimate for Vermont as of July 1, 2019: 623,989.	Total VHCURES (Excluding Self-Insured) Members	Blueprint PCMH Primary Care Attributed Members
Population N	424,700	290,335
N Adults 18+		77.7%
N Pediatric 1-17		22.3%
Avg. Age	43.9	43.5
% Female	52.8%	54.3%
% Medicaid	29.1%	30.1%
% Medicare	30.2%	30.3%
% Commercial	40.8%	39.6%
% ACG Healthy Users	7.8%	7.3%
% ACG Low Risk	13.8%	14.3%
% ACG Medium Risk	42.9%	46.3%
% ACG High Risk	16.9%	18.3%
% ACG Very High Risk	9.6%	10.1%

In the following analyses, regional breakouts are based on Vermont Department of Health HSA4 Hospital Service Areas (HSAs). A map of these HSAs can be found on the Vermont Department of health's website at http://www.healthvermont.gov/GIS/.

Population Sizes

Figure 7: Population N (Person Counts) By HSA: *Total VHCURES (Excluding Self-Insured) Population*

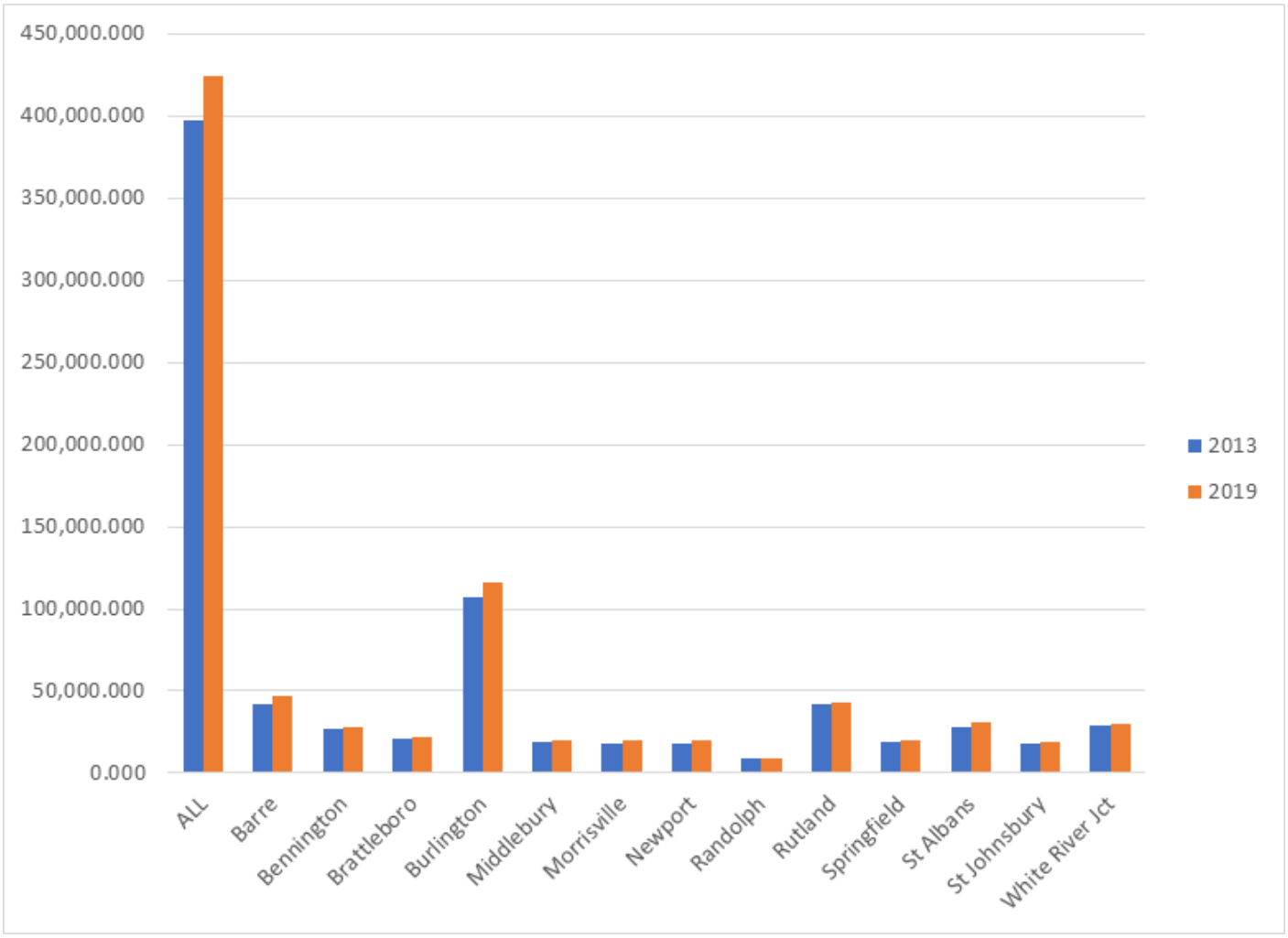


Figure 8: Expenditures Total Per Member Per Year, Risk-Adjusted by HSA (Dollars, Inflation-Adjusted): *Total VHCURES (Excluding Self-Insured) Population*

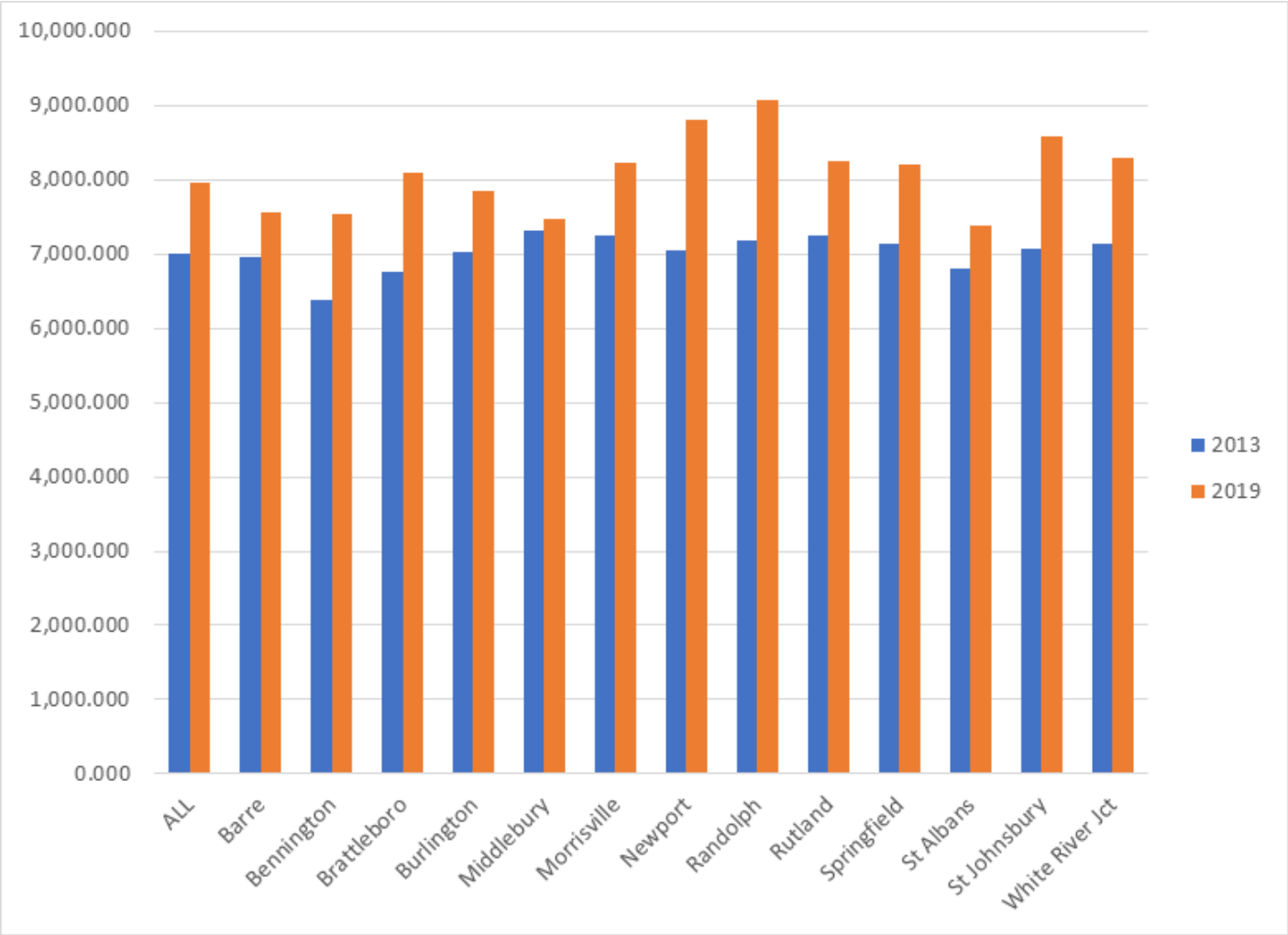
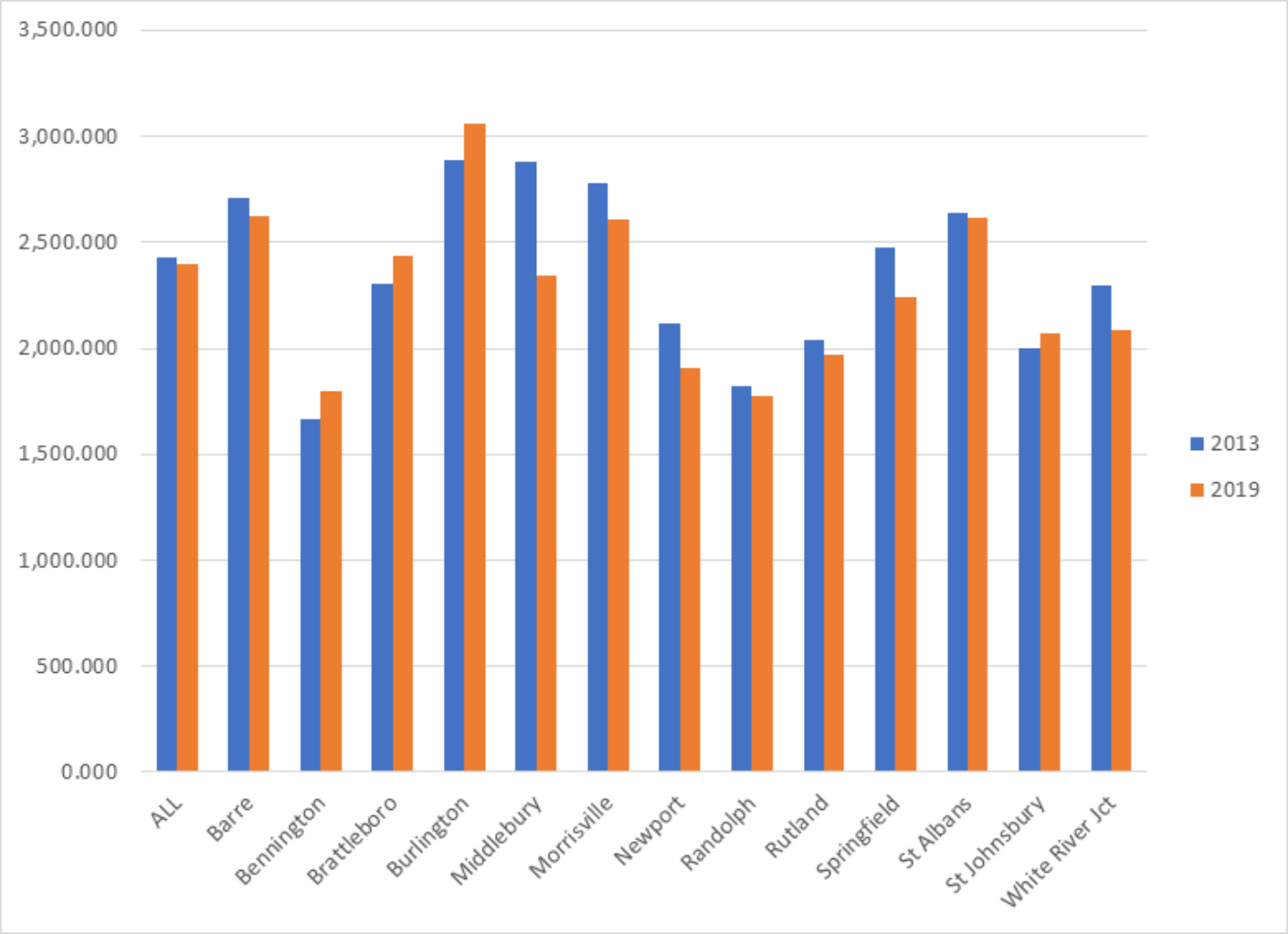


Figure 9: Expenditures Special Medicaid Services Per Member Per Year, Risk-Adjusted By HSA (Dollars, Inflation-Adjusted): *Medicaid-Primary Population*



Healthcare Quality Measures (Risk-Adjusted By HSA) Used for Blueprint Performance Payments to Primary Care Practices

Figure 10: NQF1448 Developmental Screening in the First Three Years of Life (DEV), Risk-Adjusted By HSA (Proportions): *PCMH Primary-Care-Attributed Population*

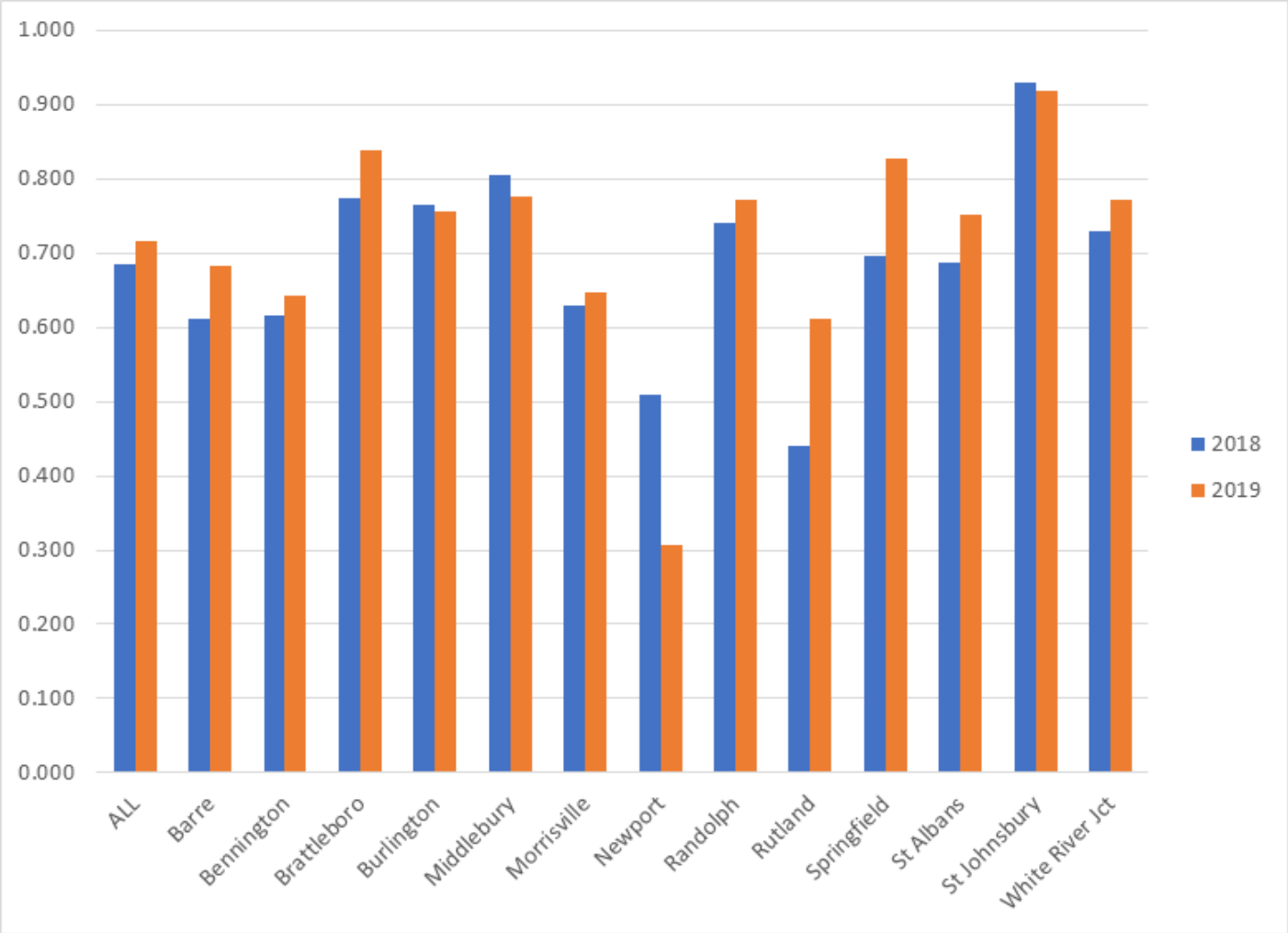


Figure 11: HEDIS Adolescent Well-Care (AWC) Visit 12-21 Years Old, Risk-Adjusted by HSA (Proportions): *PCMH Primary-Care-Attributed Population*

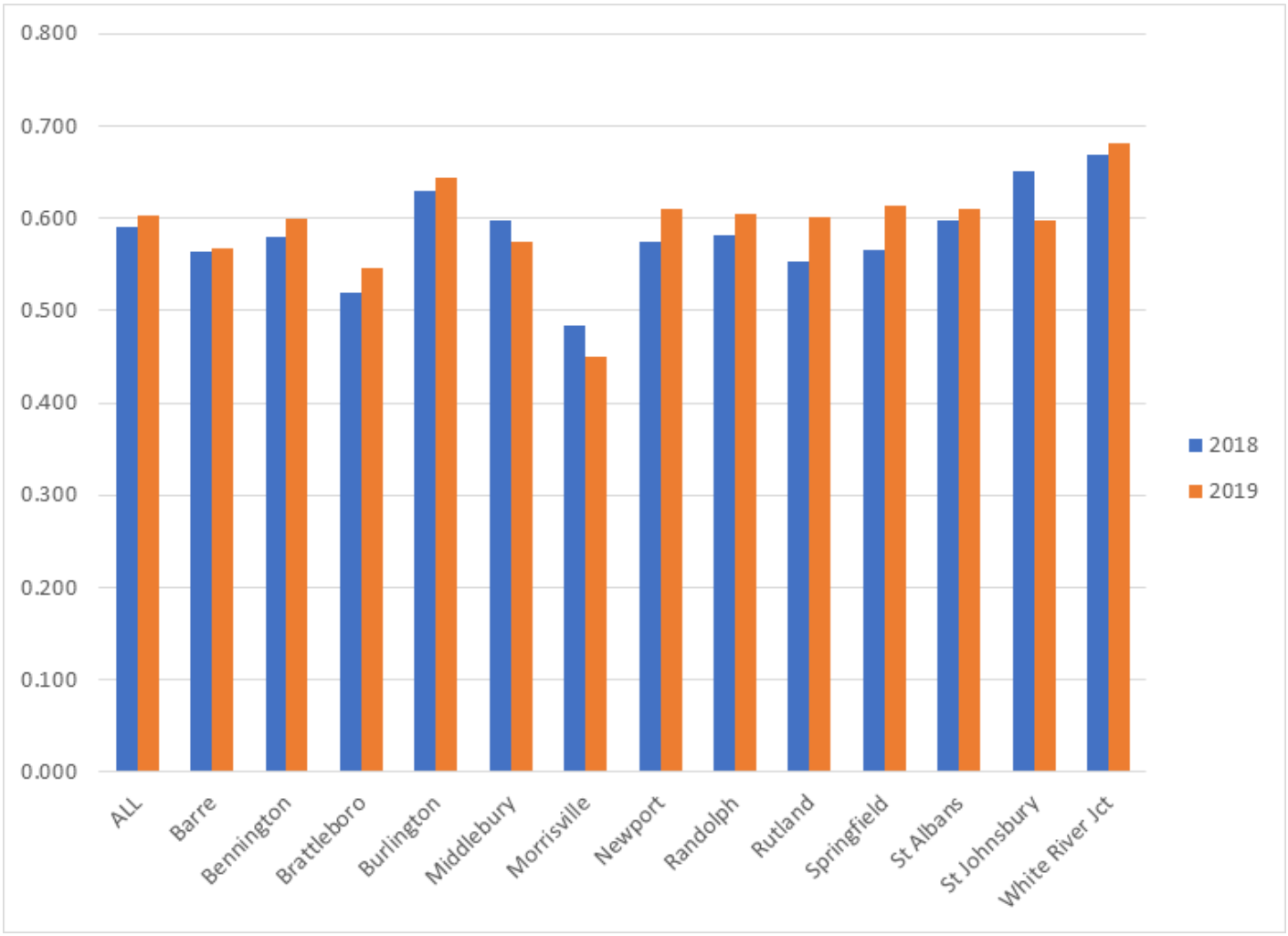


Figure 12: NQF0018 HEDIS Hypertension with Blood Pressure in Control (<140/90 mmHg) (CBP), Risk-Adjusted by HSA (Proportions): *PCMH Primary-Care-Attributed Population*

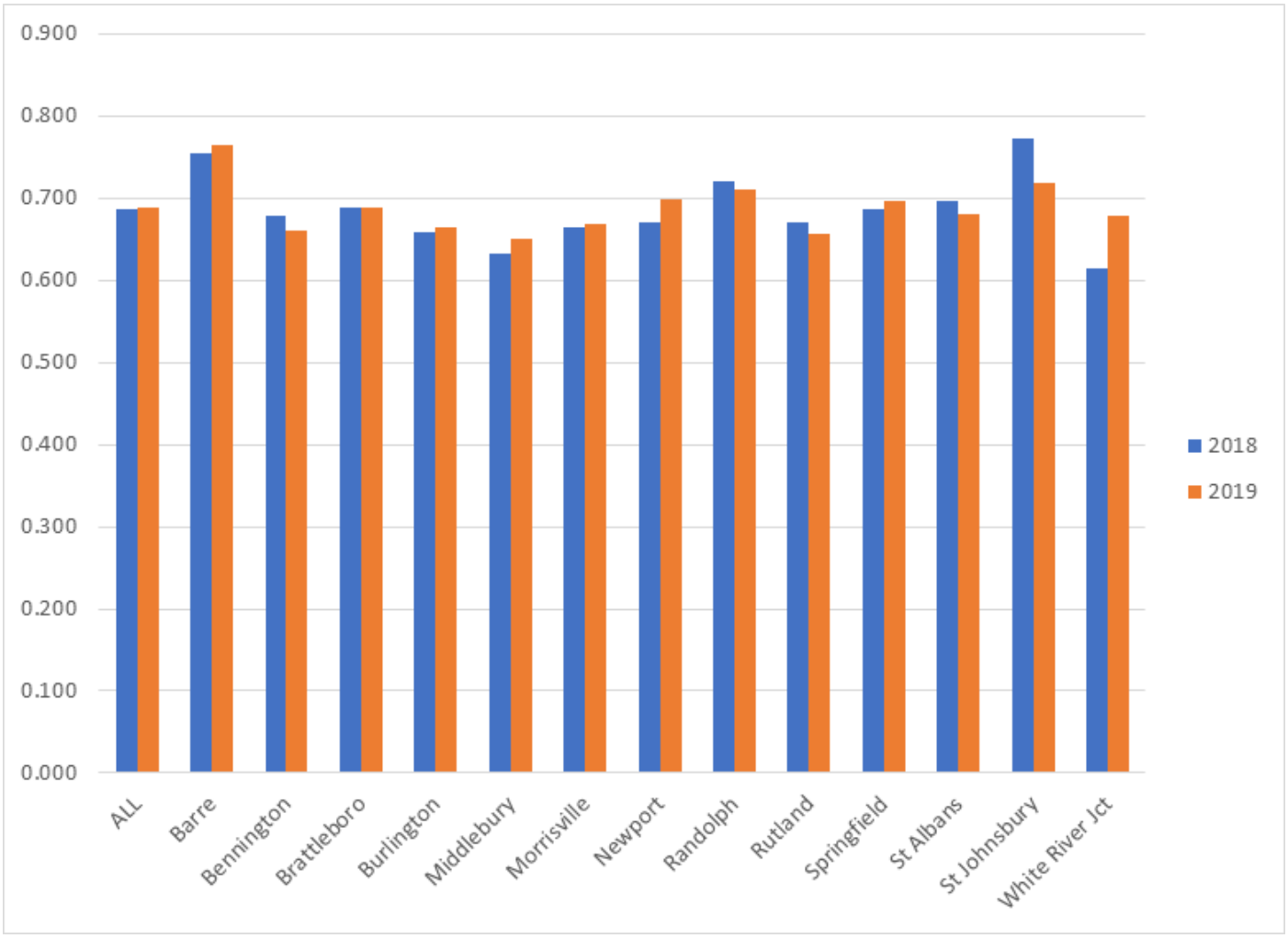
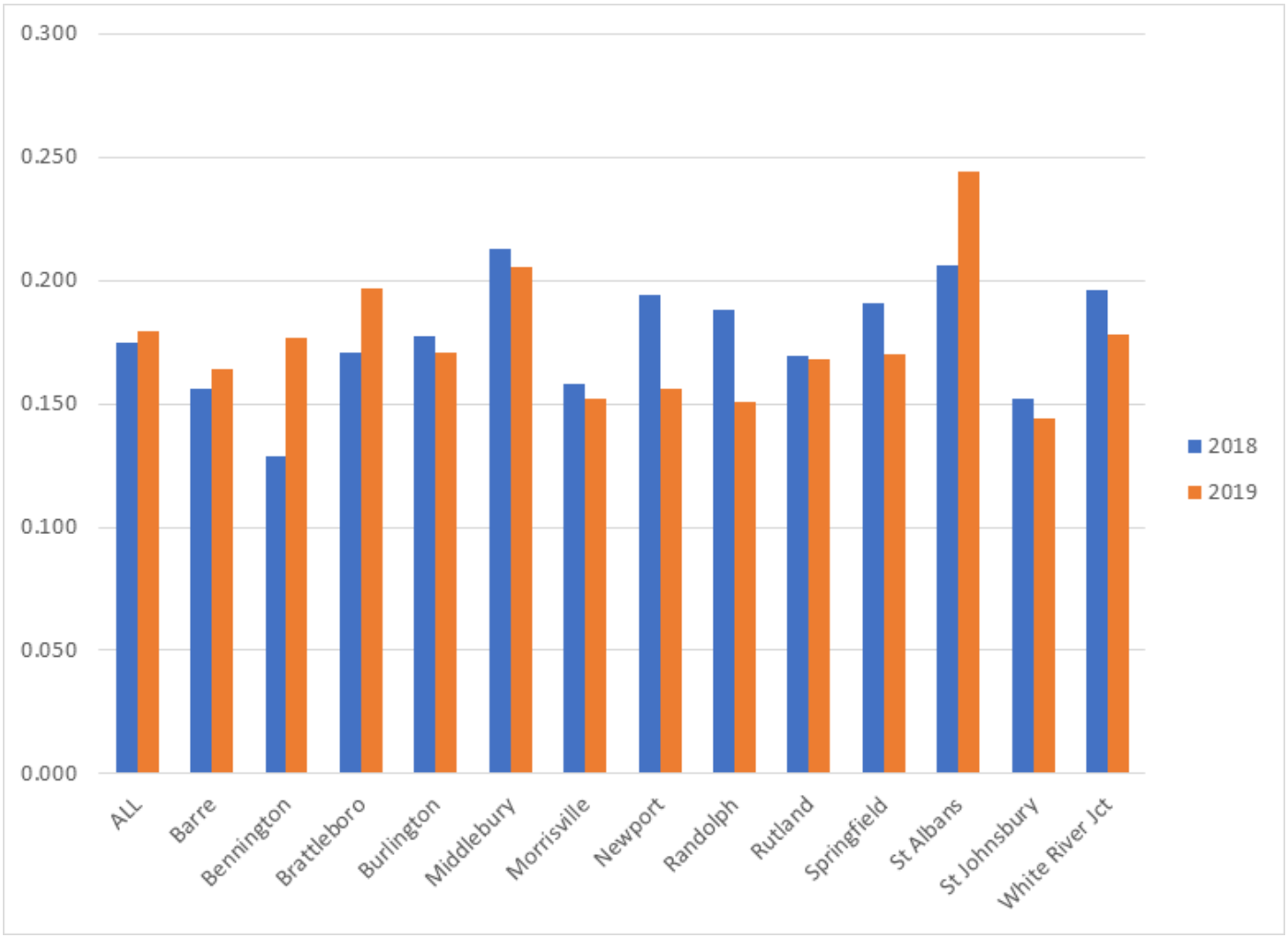


Figure 13: NQF0059 Diabetes HbA1c Not in Control (>9%) (DPC), Risk-Adjusted by HSA (Proportions) [Lower is Better]: *PCMH Primary-Care-Attributed Population*



Other Chronic Conditions

Figure 14: NQF1800 HEDIS Asthma Medication Ratio (AMR) of Controller Medications to Total Asthma Medications of .50 or Greater (Proportions): *Total VHCURES (Excluding Self-Insured) Population*

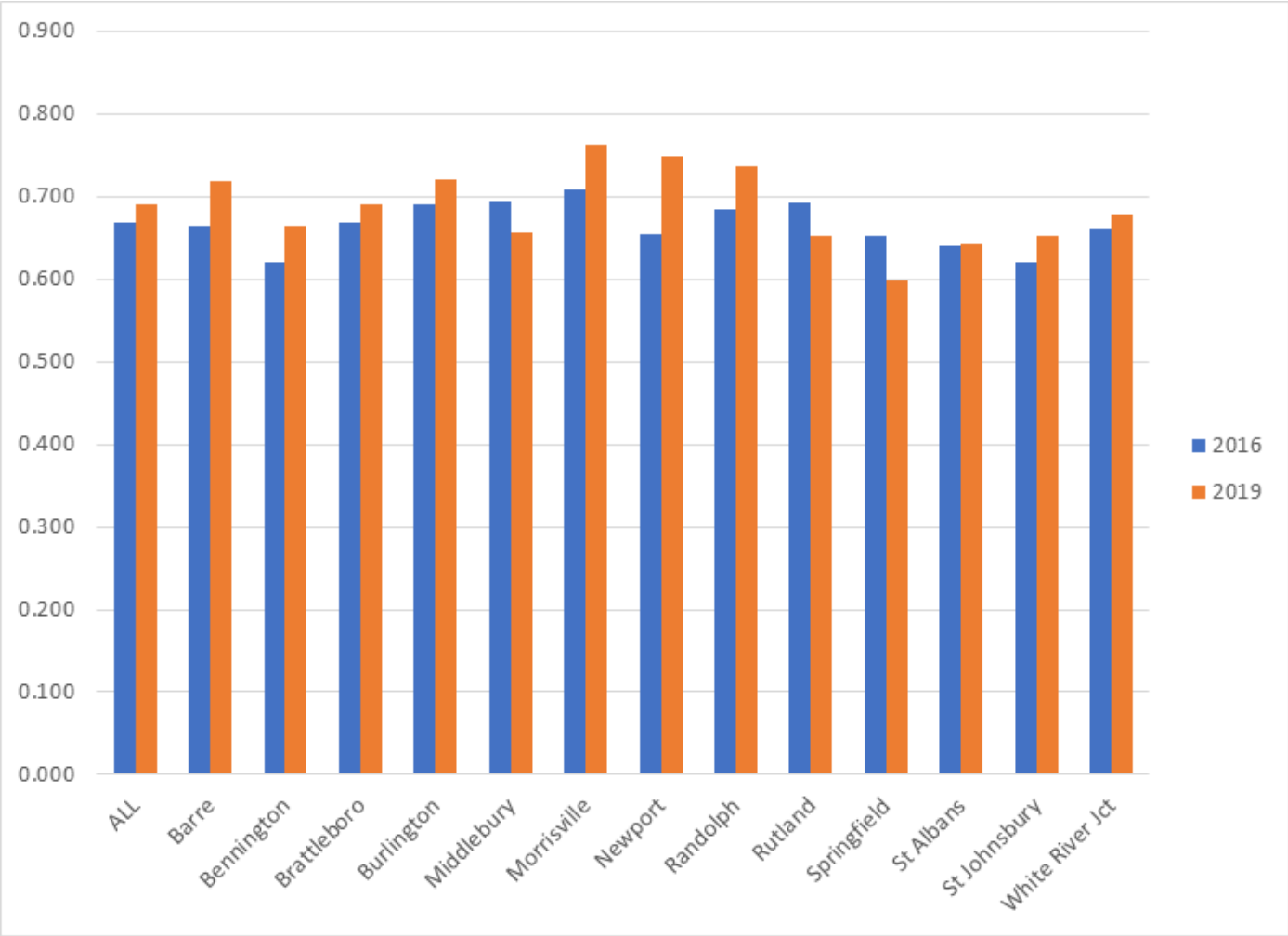


Figure 15: NQF0275 COPD & Asthma Admissions, 40 Years Old Plus (COPD-PQI05) (Admissions Per 100K Population): *Total VHCURES (Excluding Self-Insured) Population*

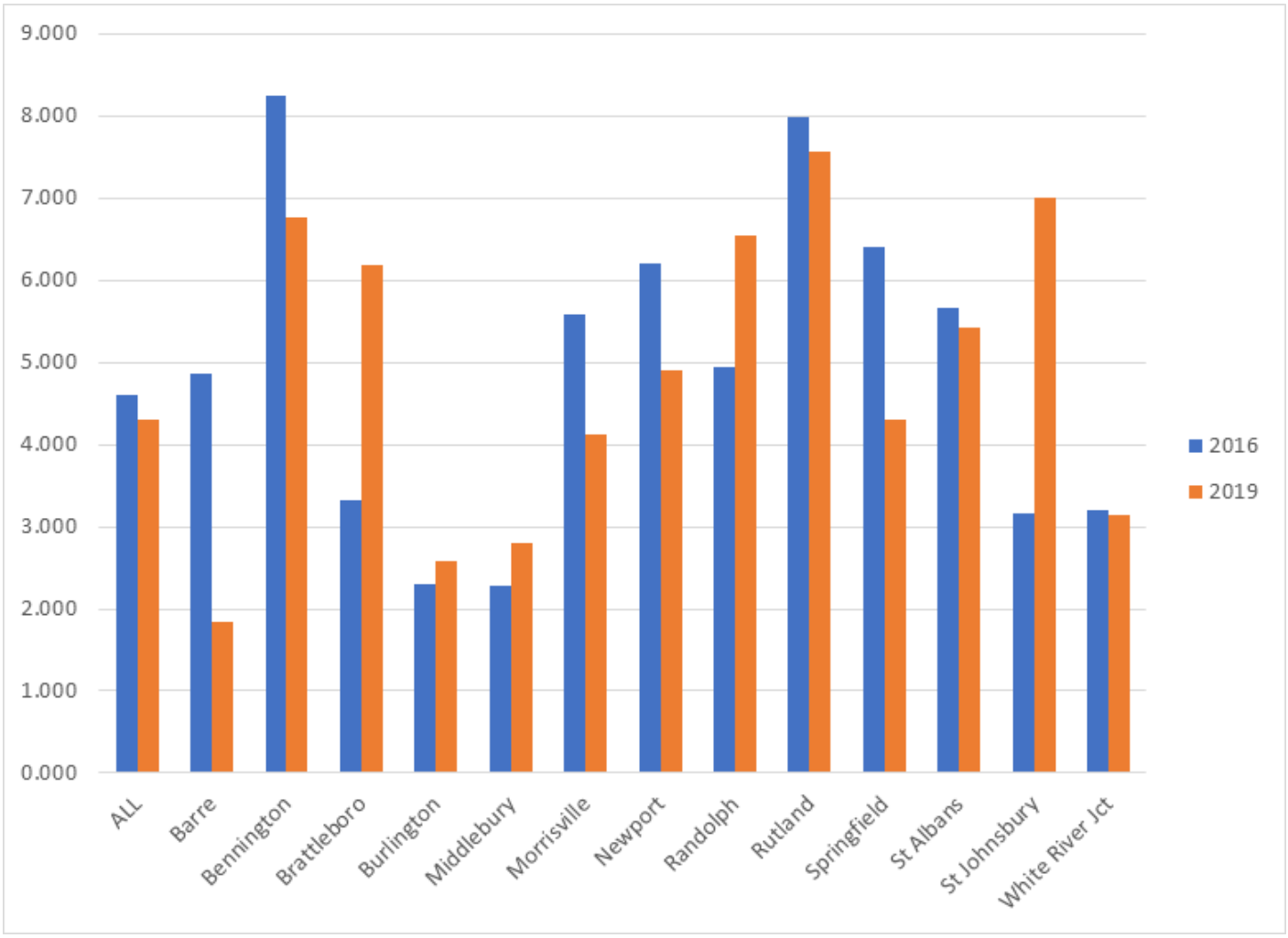


Figure 16: NQF0277 Heart Failure Admissions (PQI08) (Admissions Per 100K Population): *Total VHCURES (Excluding Self-Insured) Population*

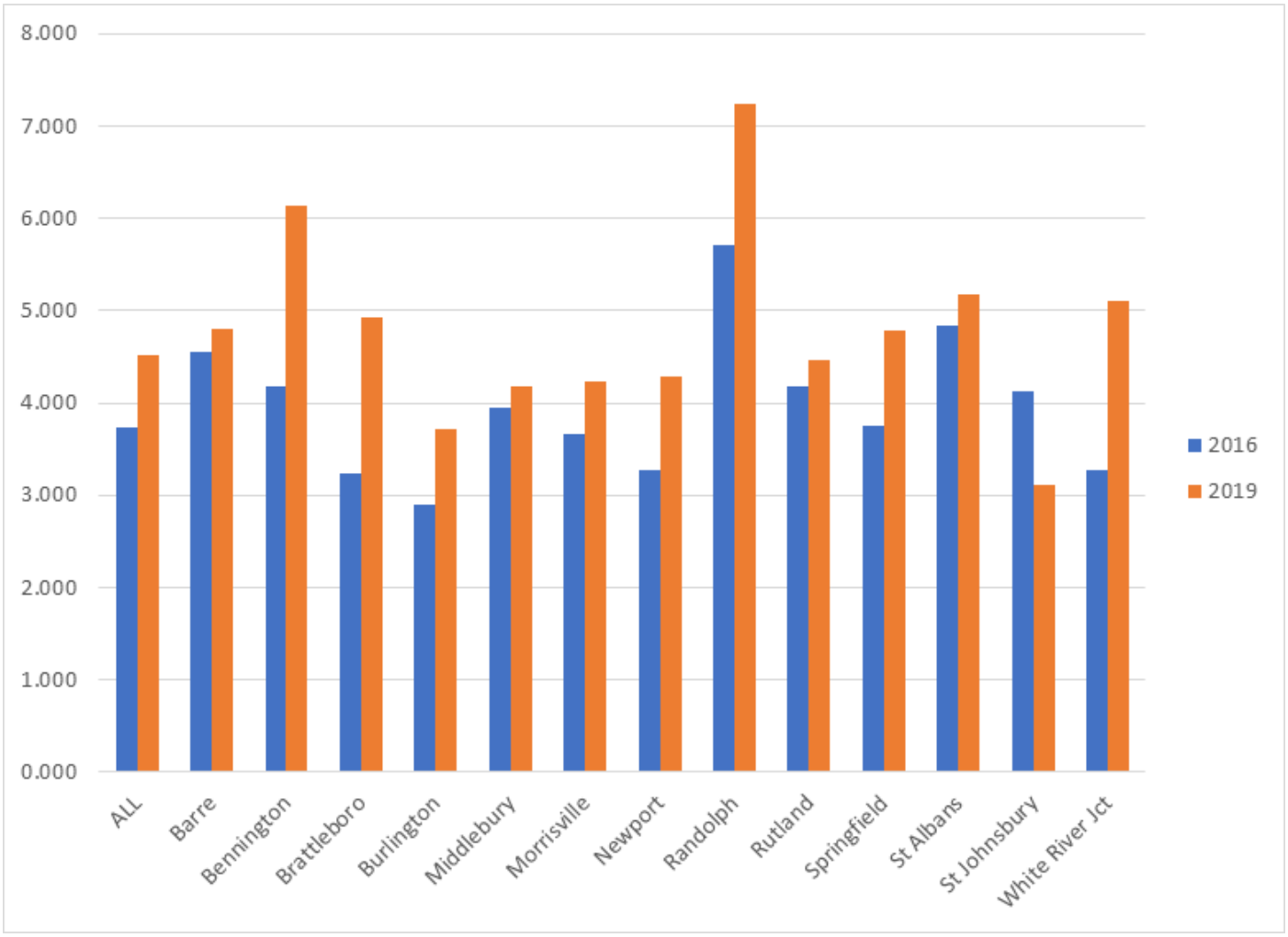


Figure 17: NQF0032 HEDIS Cervical Cancer Screening (CCS) (Proportions): *Total VHCURES (Excluding Self-Insured) Population*

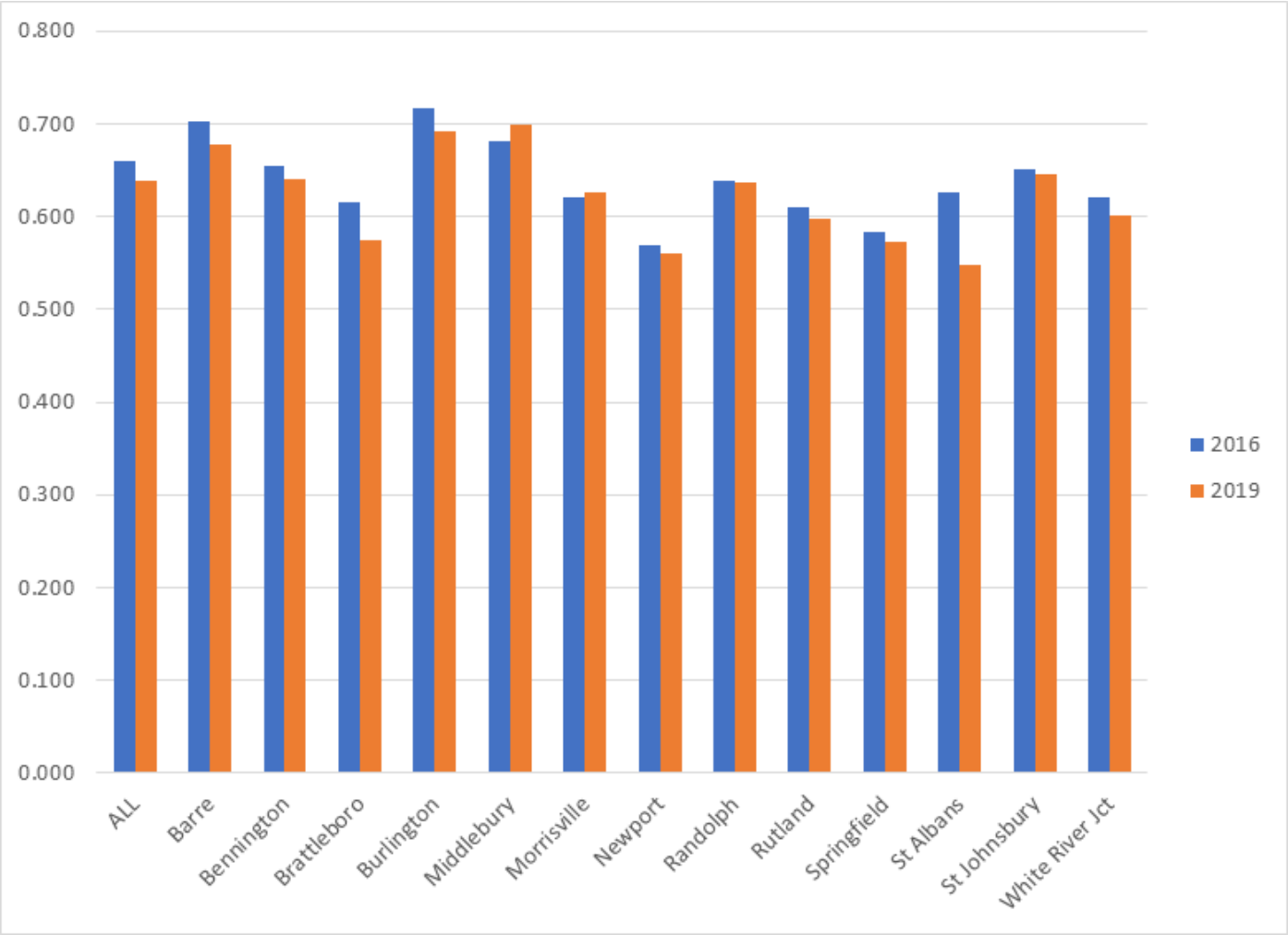
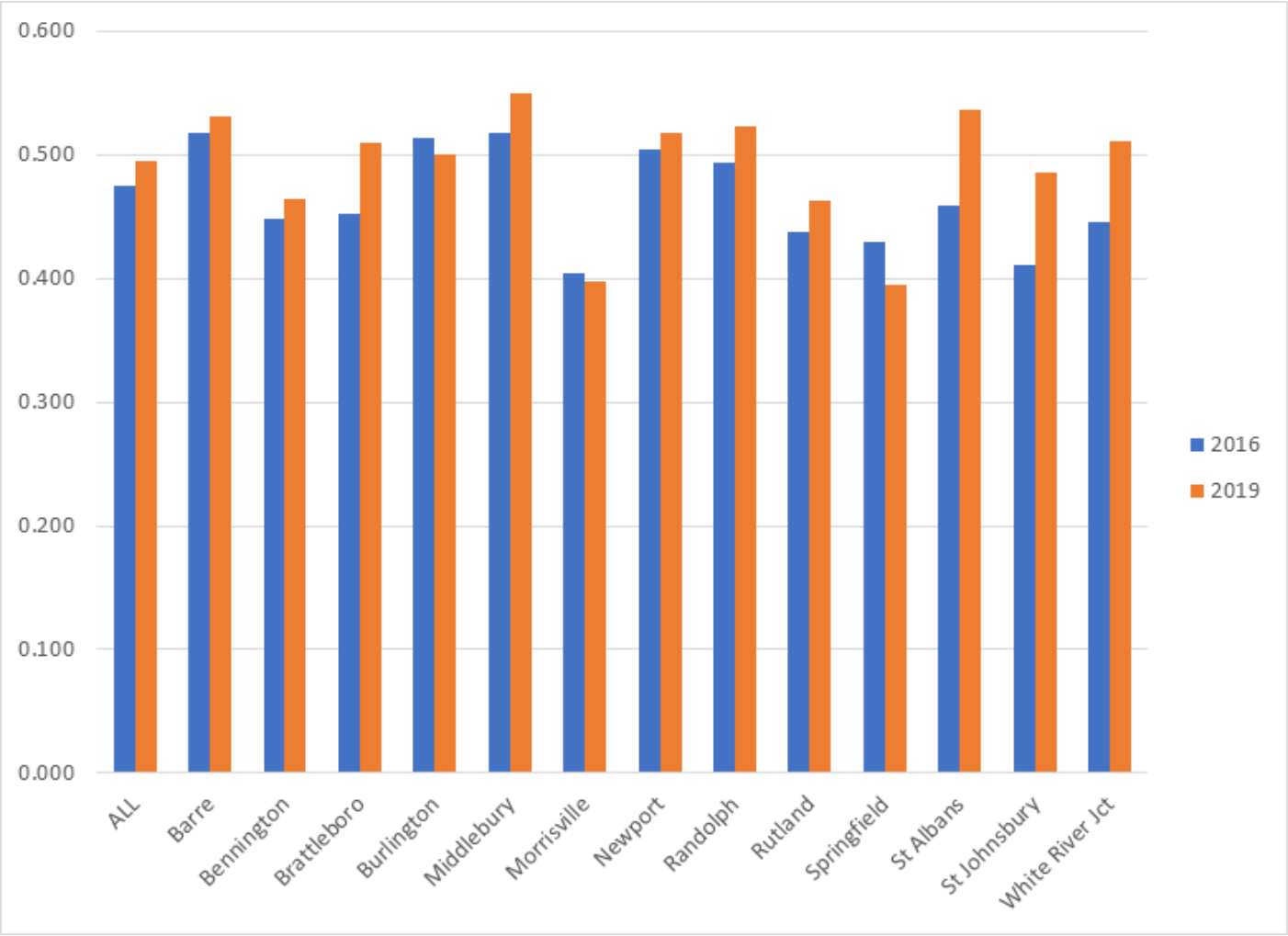


Figure 18: NQF0033 HEDIS Chlamydia Screening in Women, 16-24 Years Old (CHL) (Proportions):
Total VHCURES (Excluding Self-Insured) Population



Access-To-Care and Healthcare Utilization Measures

As stated above, 68.4% of VHCURES members were served by PCMHs in CY 2019. 92.3% of VHCURES members had any primary care visit during CY 2019, which was a slight increase over 90% in CY 2013.

Figure 19: NQF1448 Developmental Screening in the First Three Years of Life (DEV), Non-Risk-Adjusted (Proportions): *Total VHCURES (Excluding Self-Insured) Population*

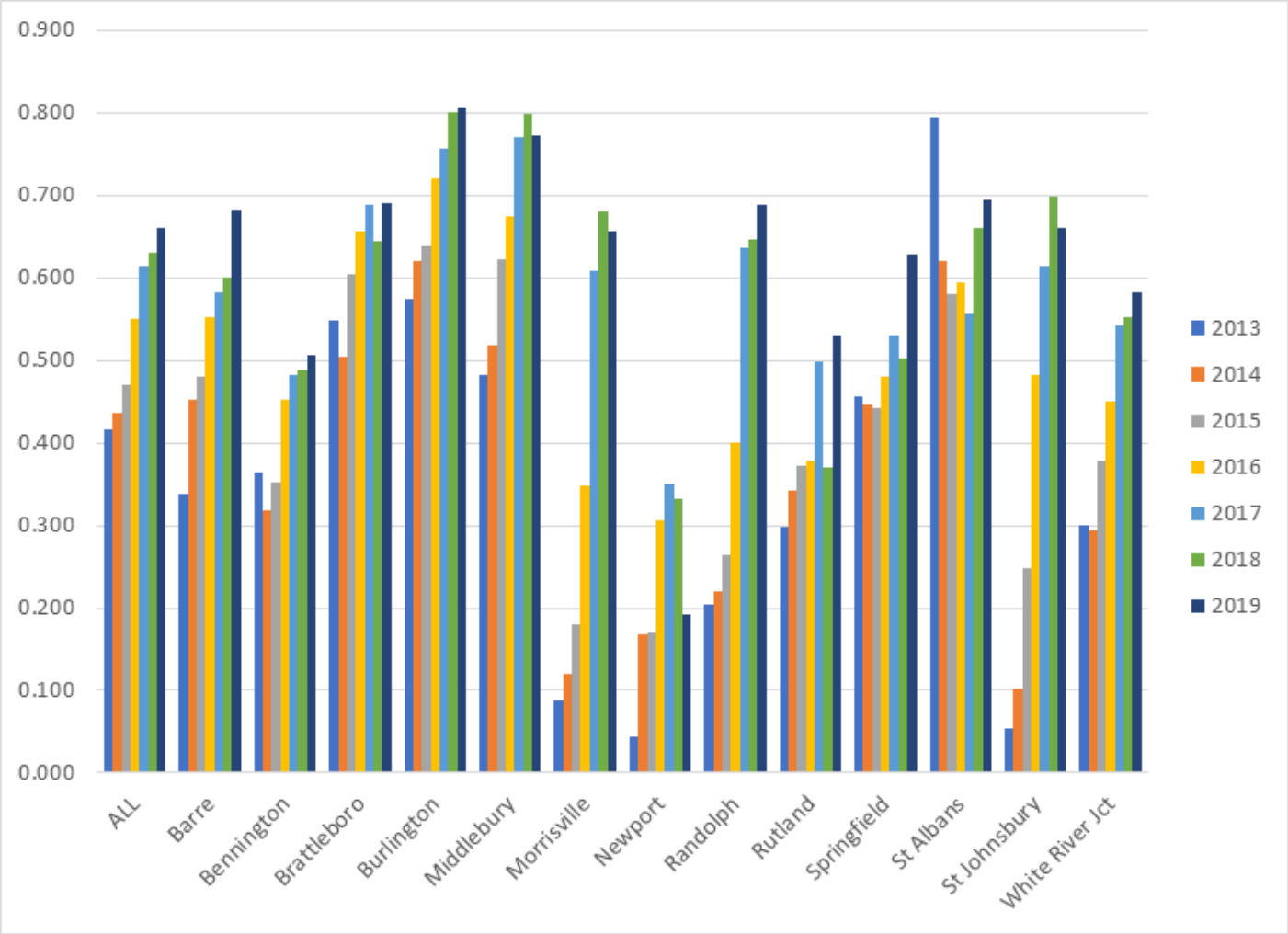


Figure X: HEDIS Adolescent Well-Care (AWC) Visit 12-21 Years Old, Non-Risk Adjusted (Proportions):
Total VHCURES (Excluding Self-Insured) Population

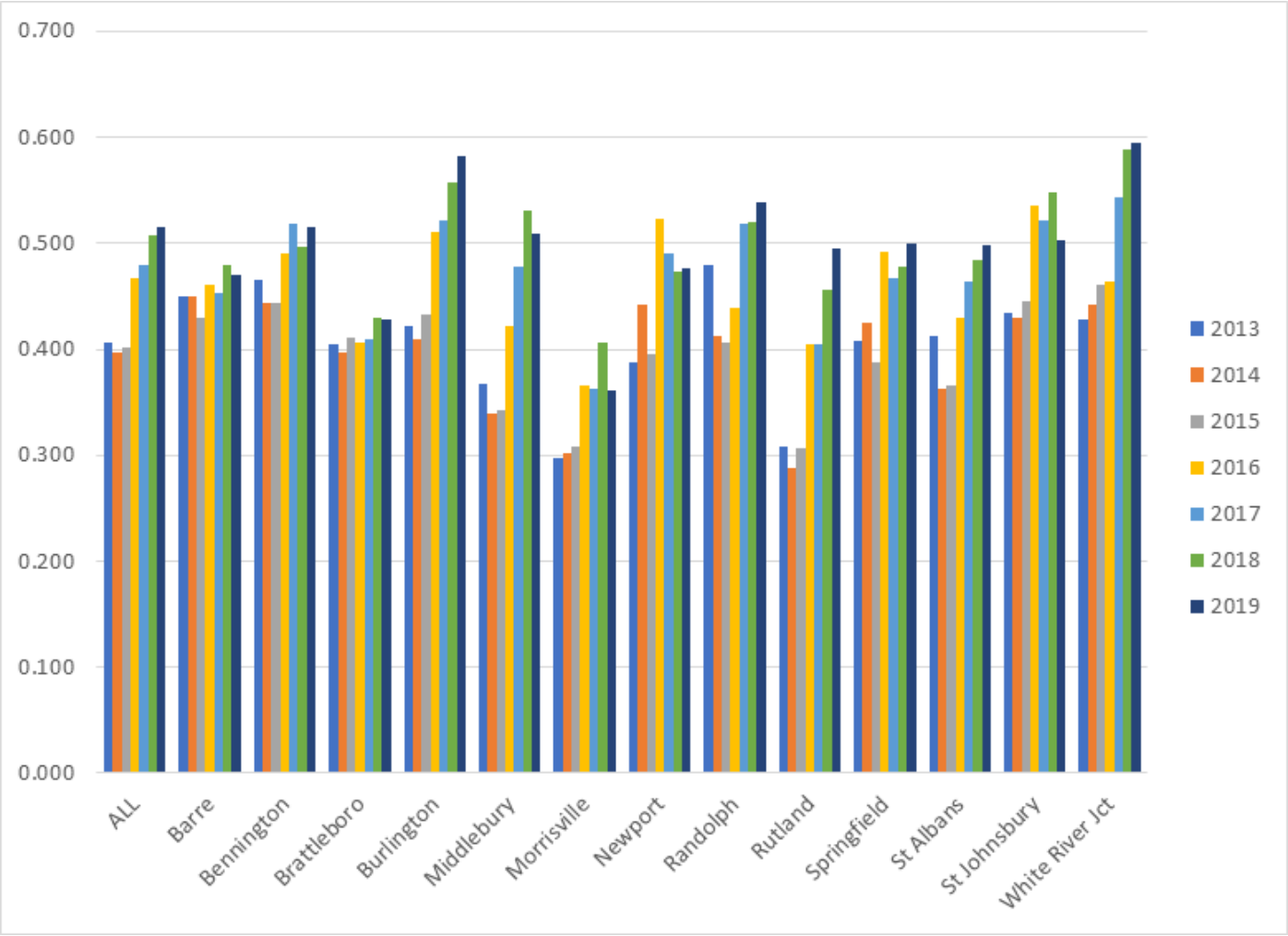


Figure 20: Primary Care Encounters / 1000 Member Years: *Total VHCURES (Excluding Self-Insured) Population*

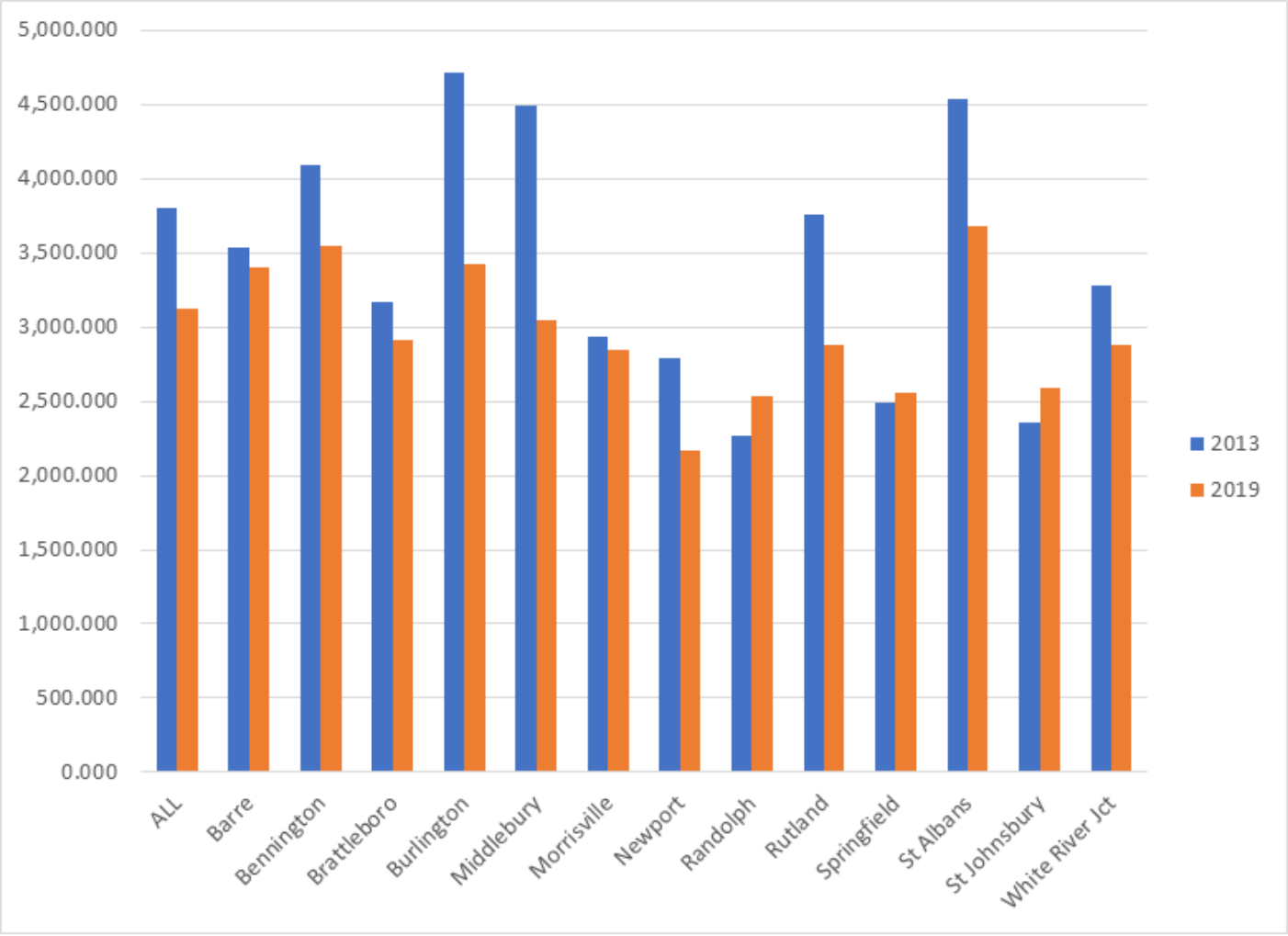


Figure 21: Medical Specialist Encounters / 1000 Member Years: *Total VHCURES (Excluding Self-Insured) Population*

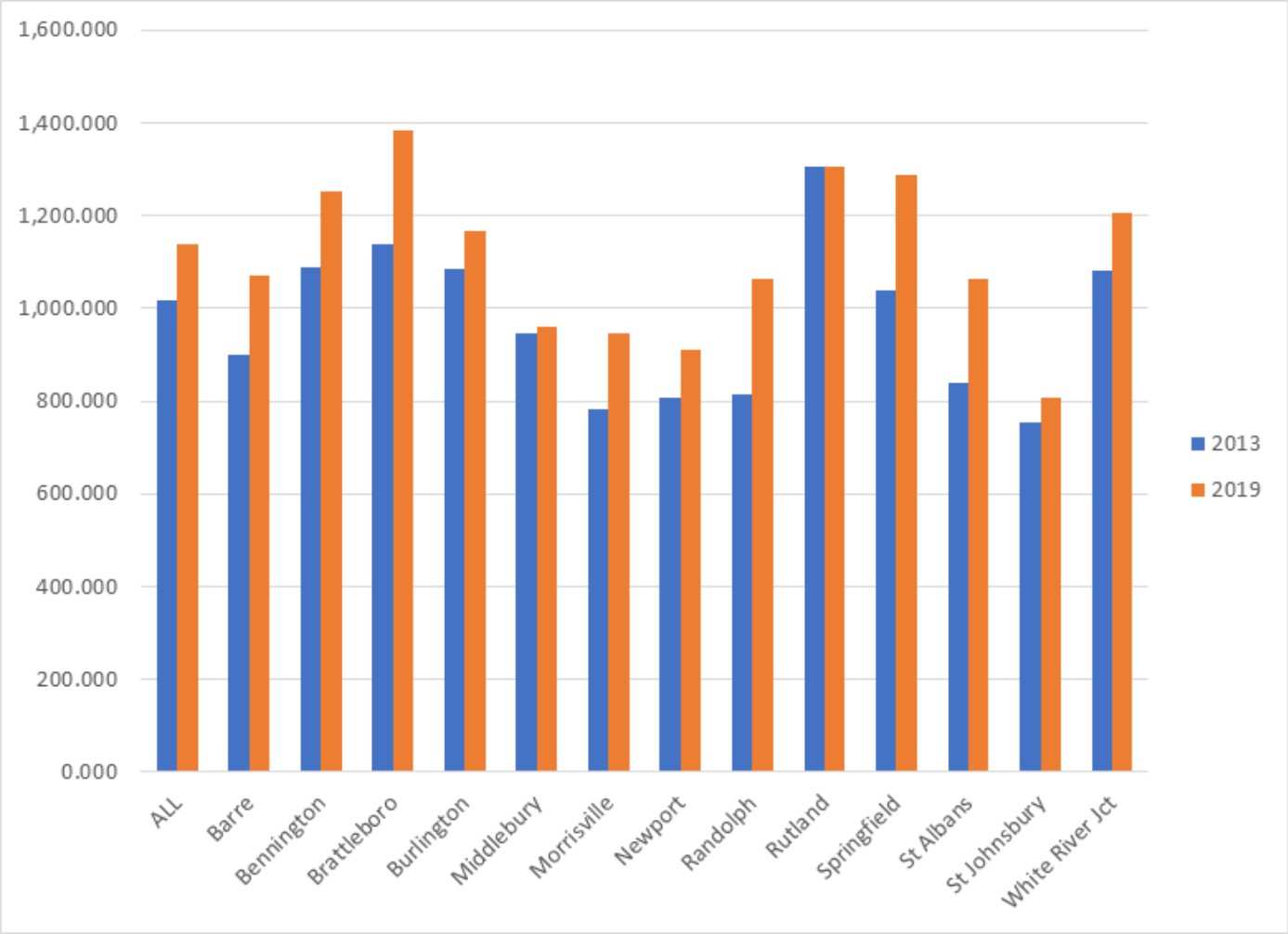


Figure 22: Surgical Specialist Encounters / 1000 Member Years: *Total VHCURES (Excluding Self-Insured) Population*

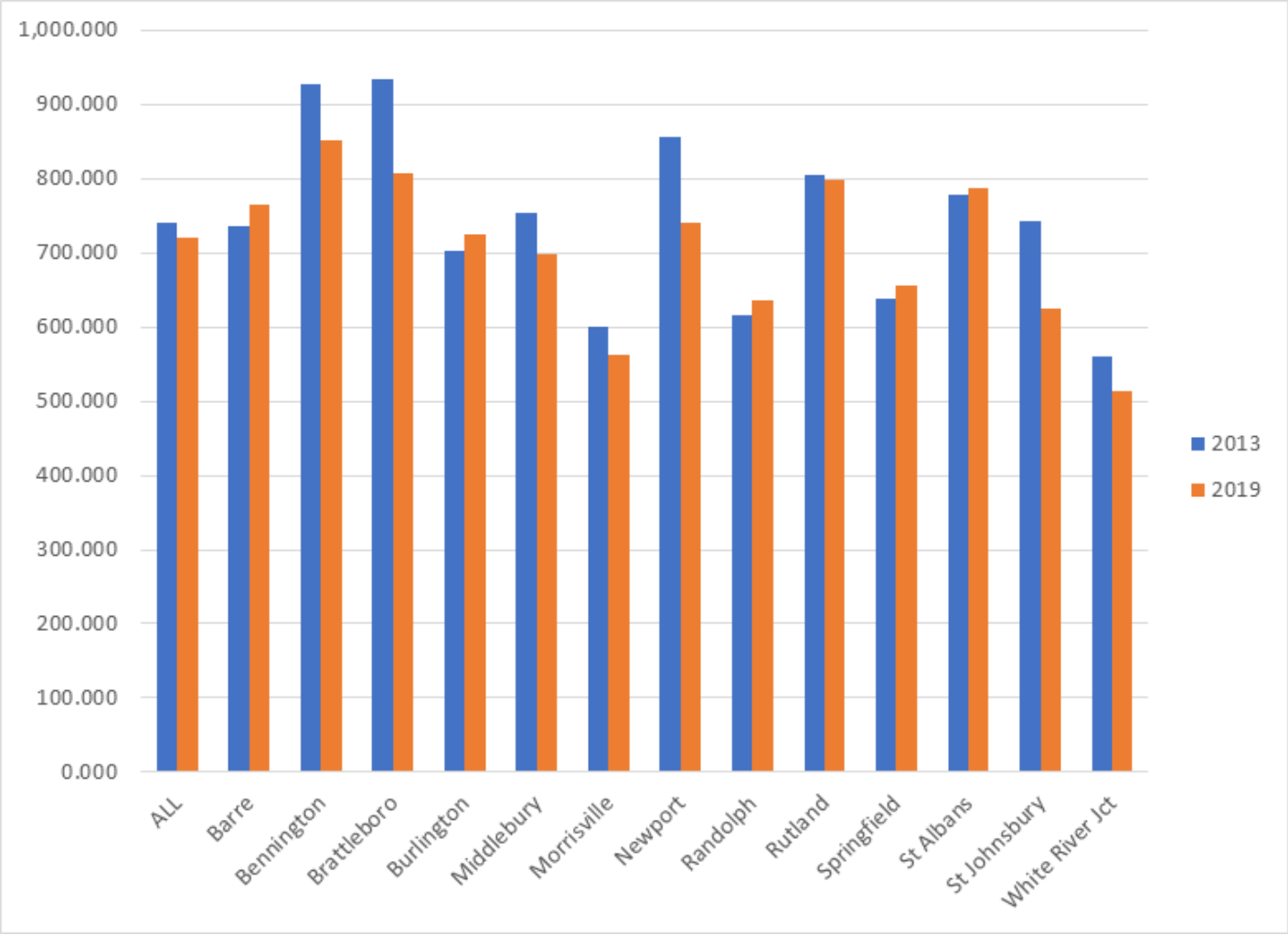


Figure 23: Outpatient Emergency Department Visits / 1000 Member Years: *Total VHCURES (Excluding Self-Insured) Population*

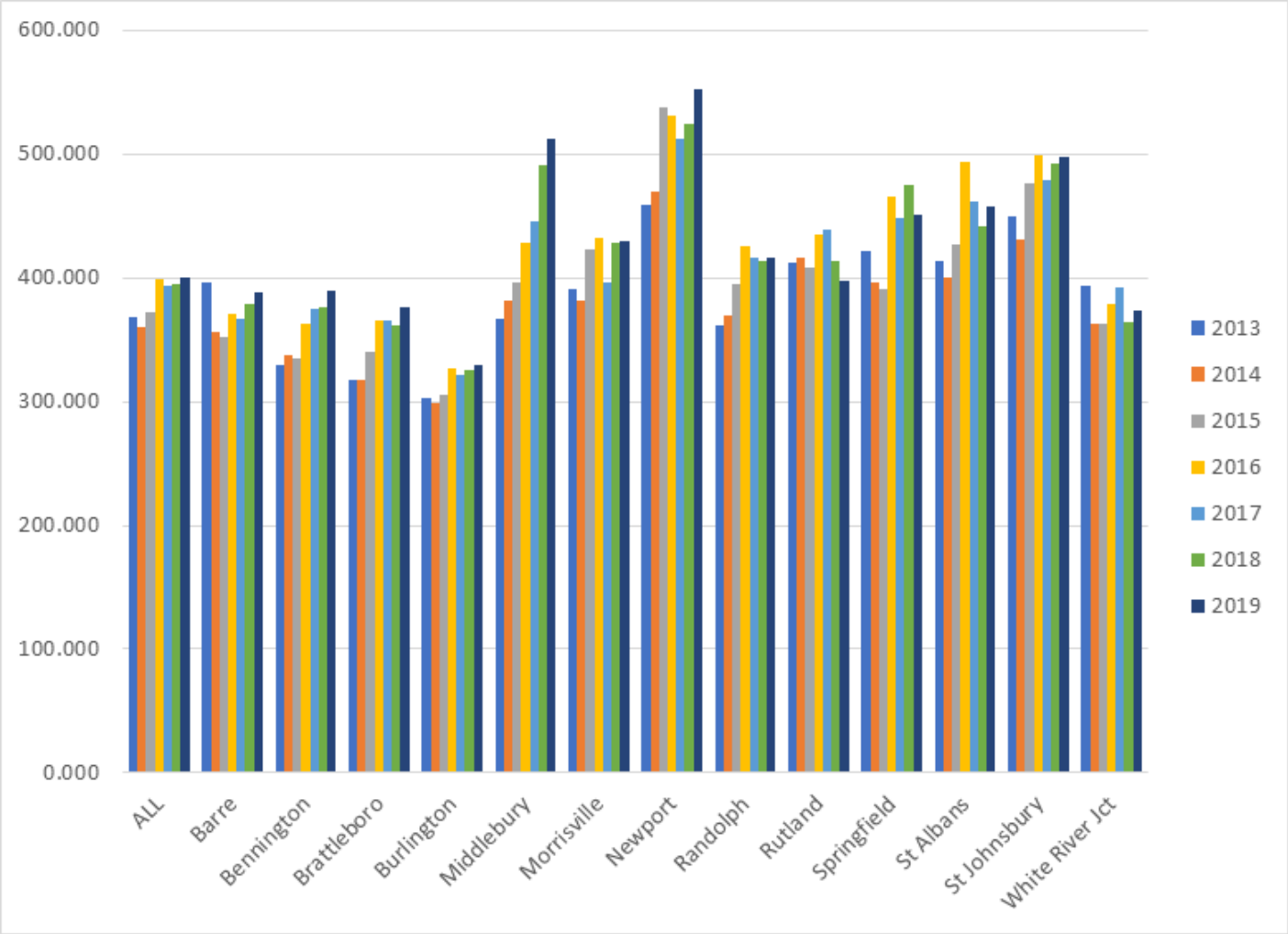


Figure 24: Inpatient Discharges / 1000 Member Years: *Total VHCURES (Excluding Self-Insured) Population*

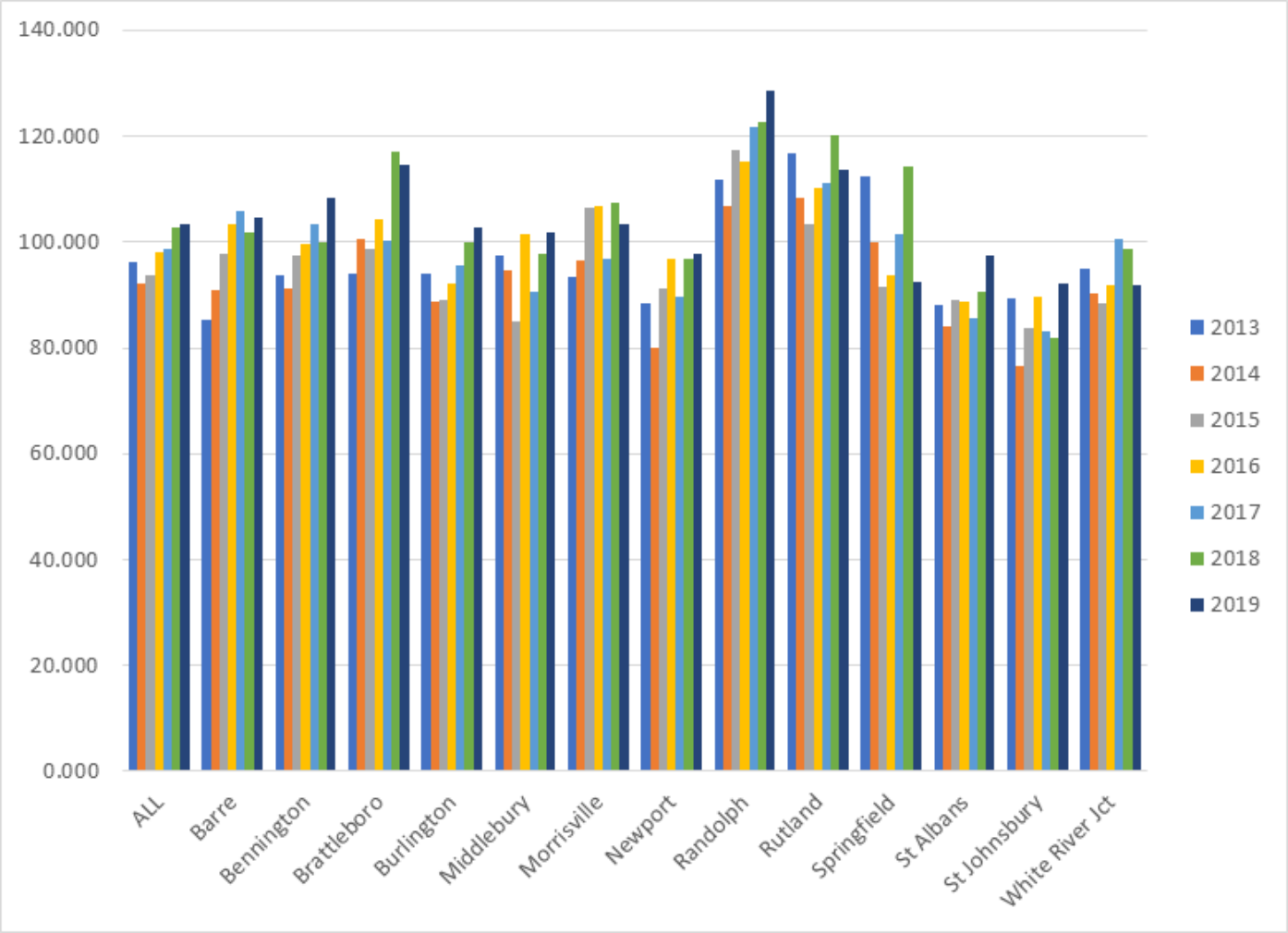


Figure 25: Outpatient Potentially Avoidable Emergency Department Visits / 1000 Member Years: *Total VHCURES (Excluding Self-Insured) Population*

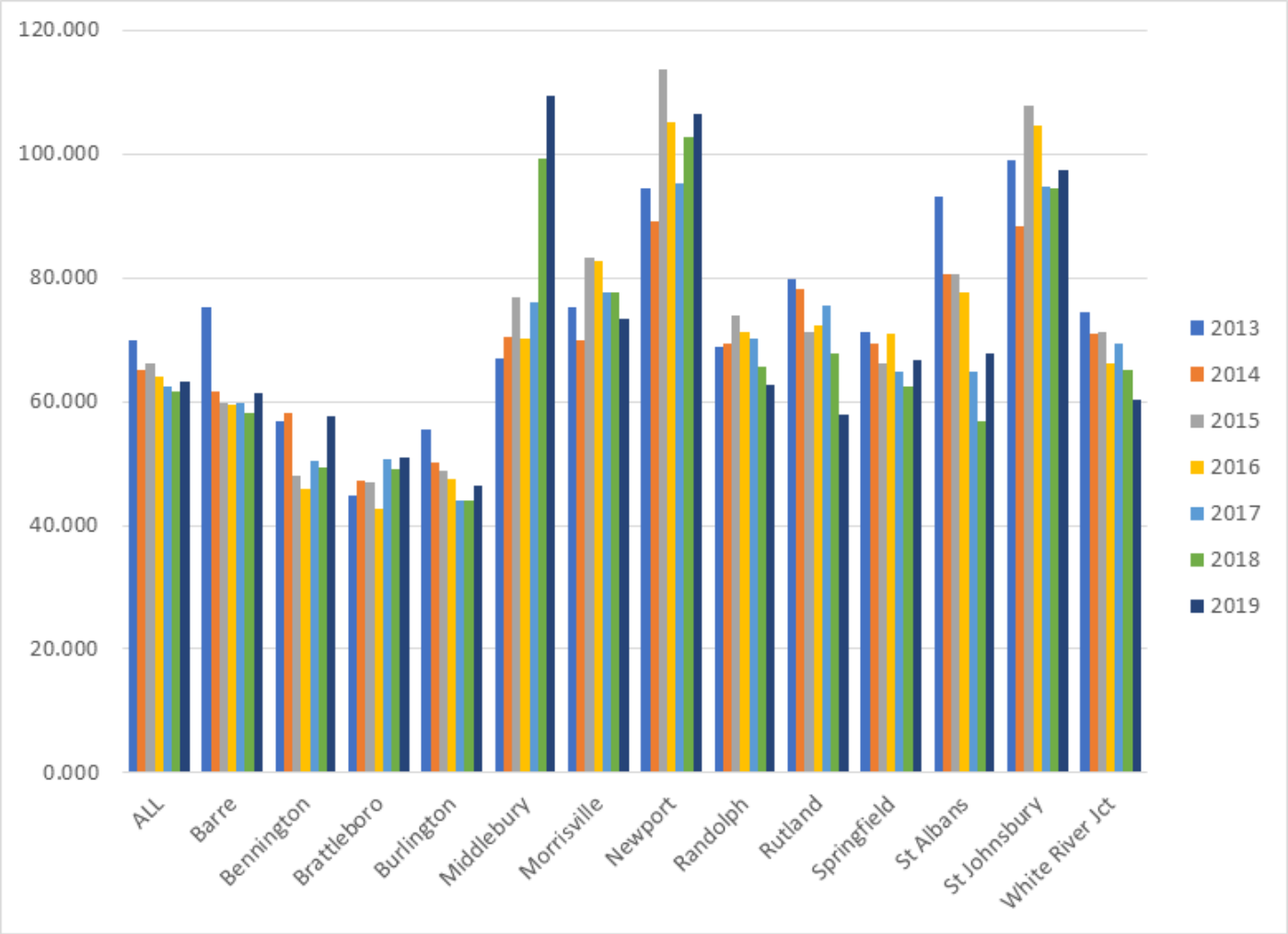


Figure 26: PQI92 Chronic Composite - Ambulatory Care Sensitive Condition Inpatient Discharges / 1000 Member Years: *Total VHCURES (Excluding Self-Insured) Population*

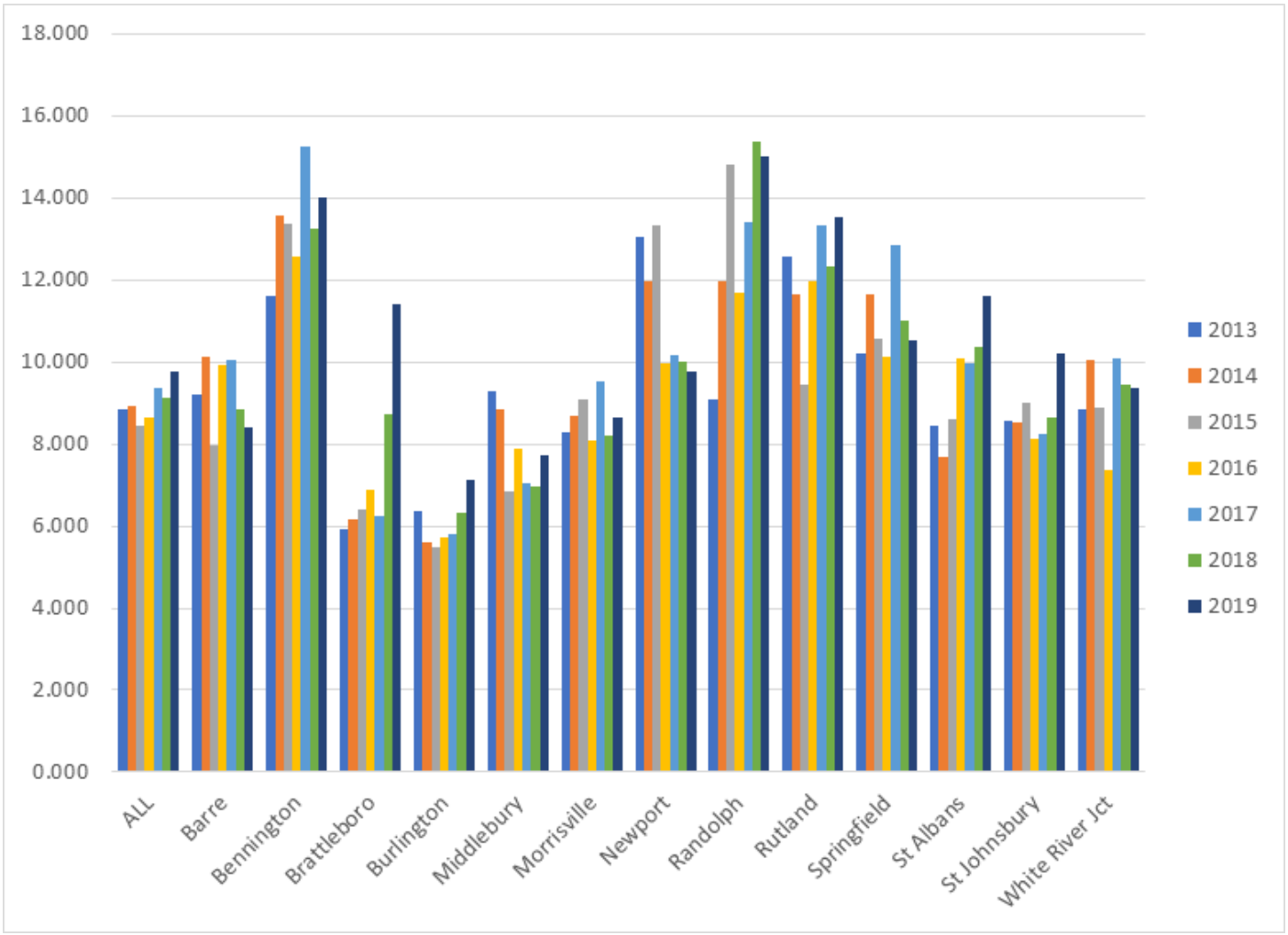


Figure 27: NQF0004 HEDIS Initiation of Alcohol and Drug Treatment Within 14 Days of Diagnosis (IET) (Proportion): *Total VHCURES (Excluding Self-Insured) Population*

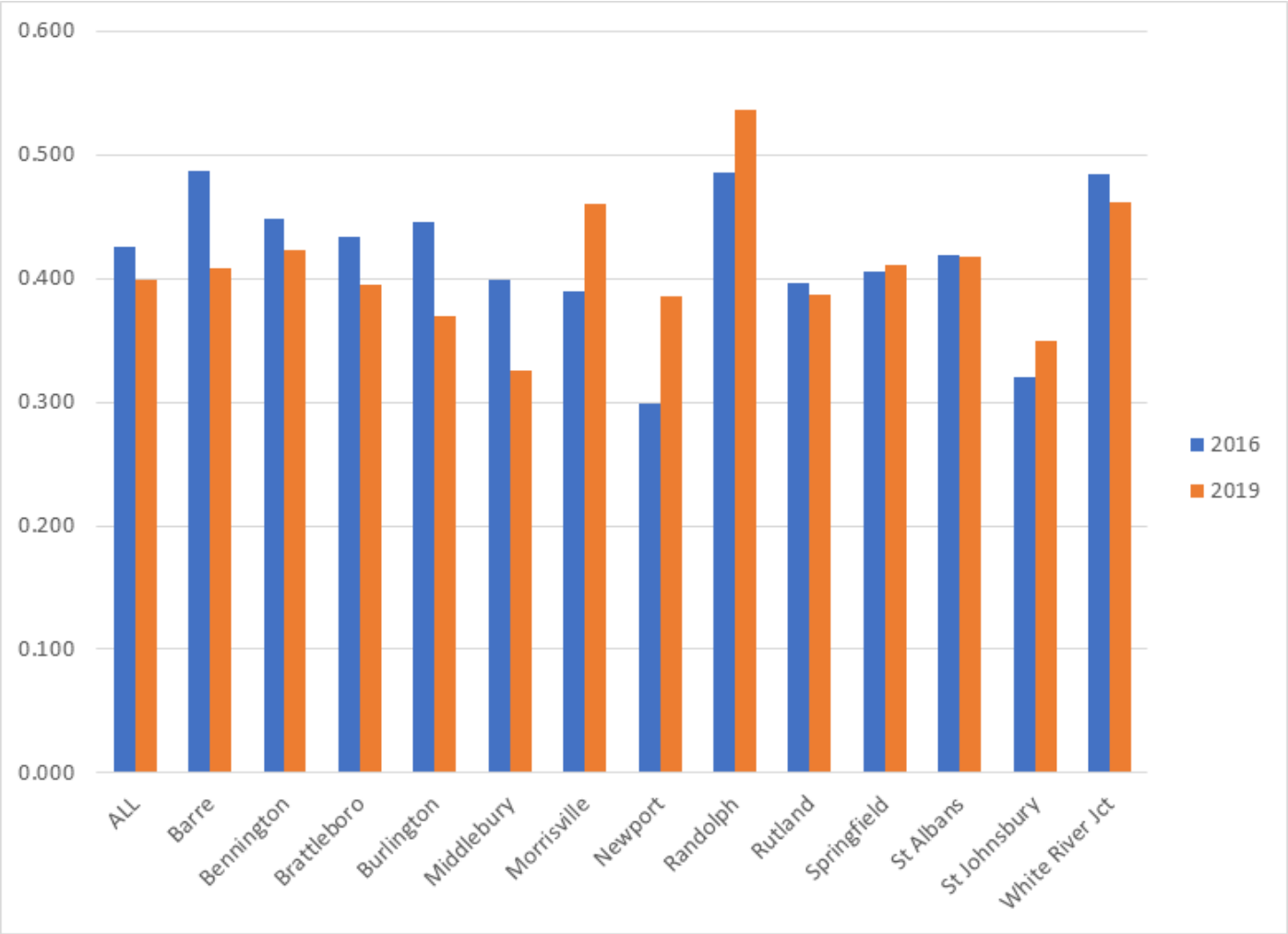


Figure 28: NQF0004 HEDIS Engagement of Alcohol and Drug Treatment (Multiple Services) Within 30 Days of Treatment Initiation (IET) (Proportion): *Total VHCURES (Excluding Self-Insured) Population*

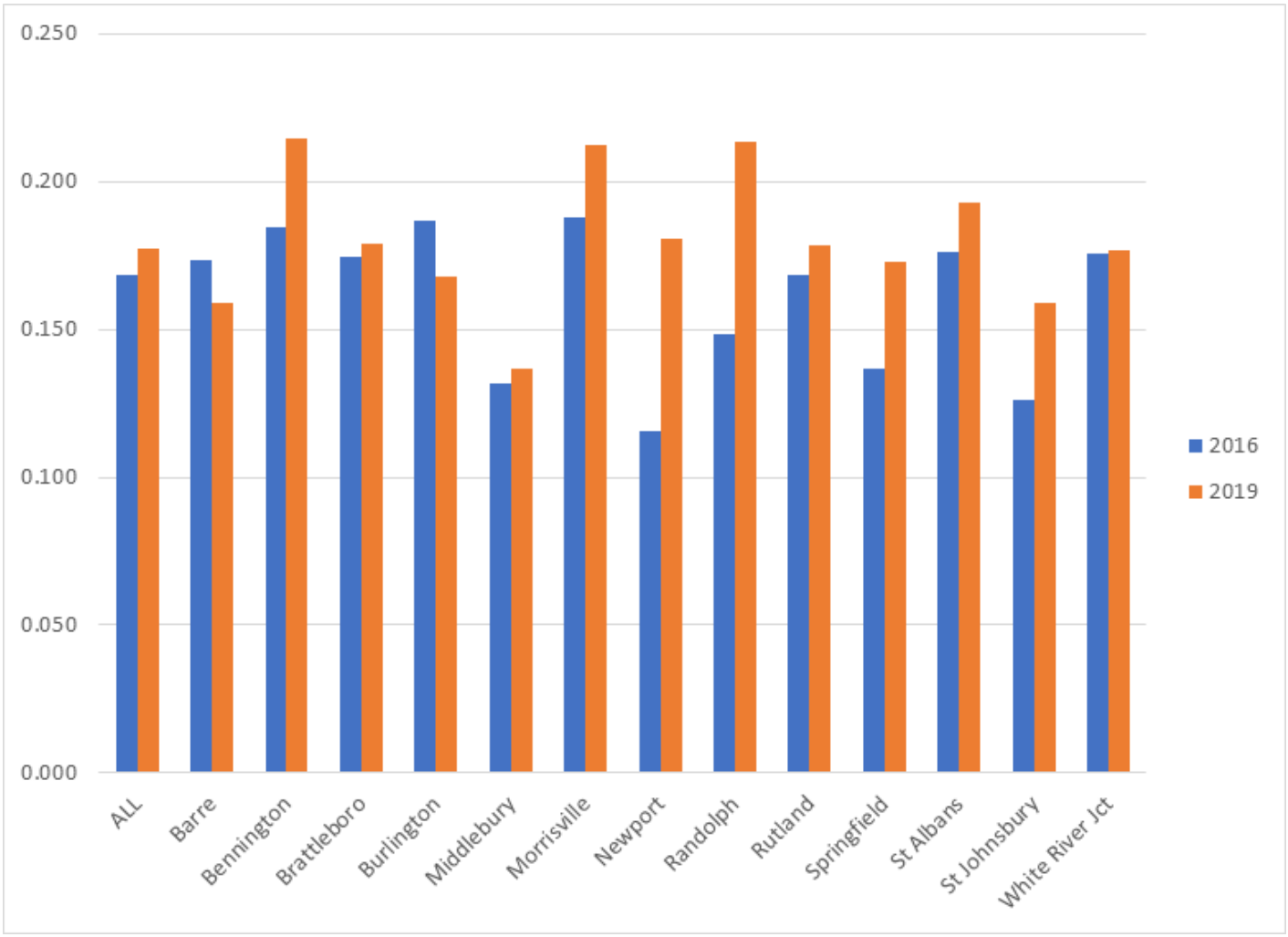


Figure 29: NQF3488 HEDIS Emergency Department Visits for Substance Use Disorder, With Follow-Up in 30 Days (FUA) (Proportion): *Total VHCURES (Excluding Self-Insured) Population*

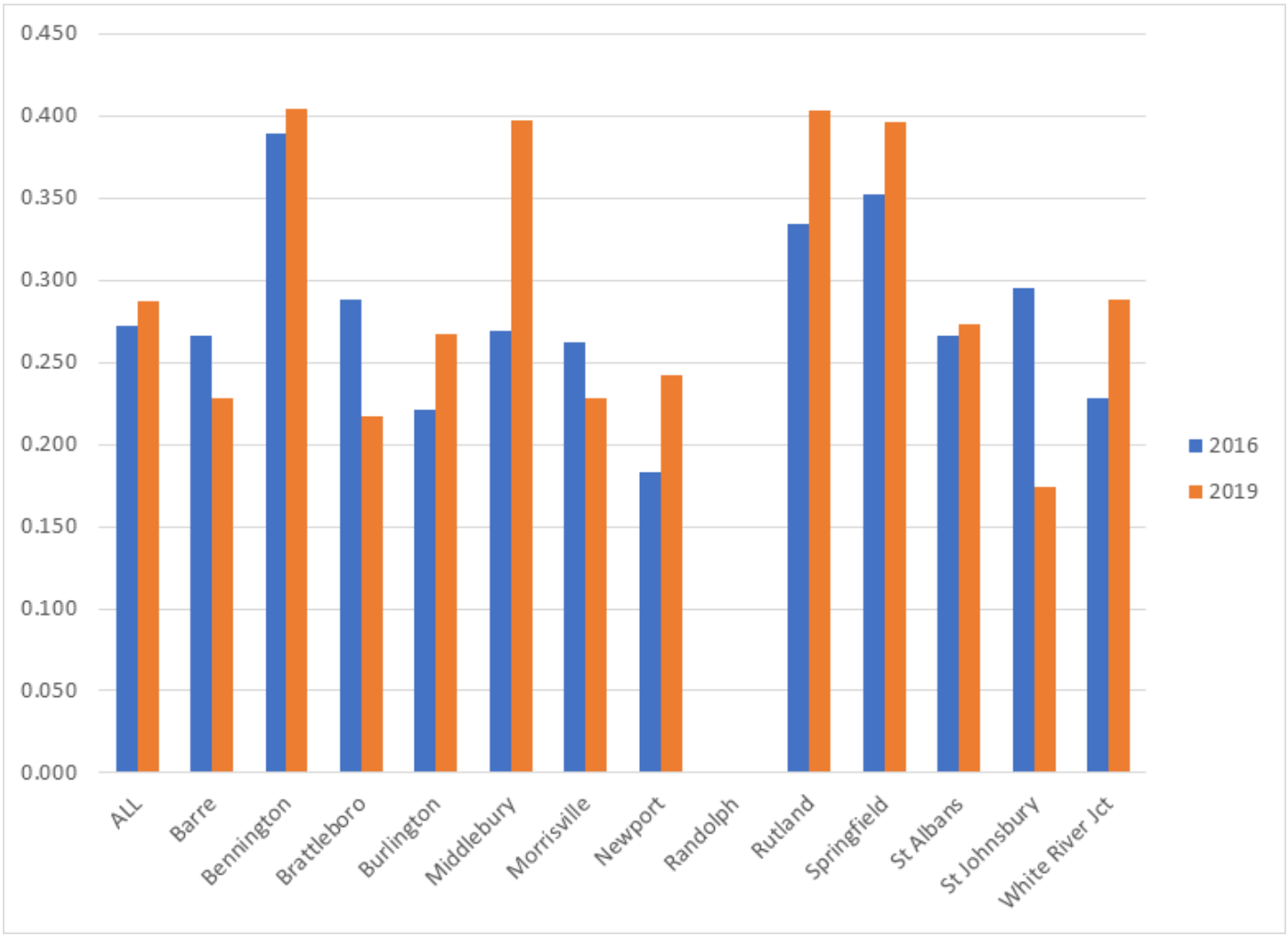
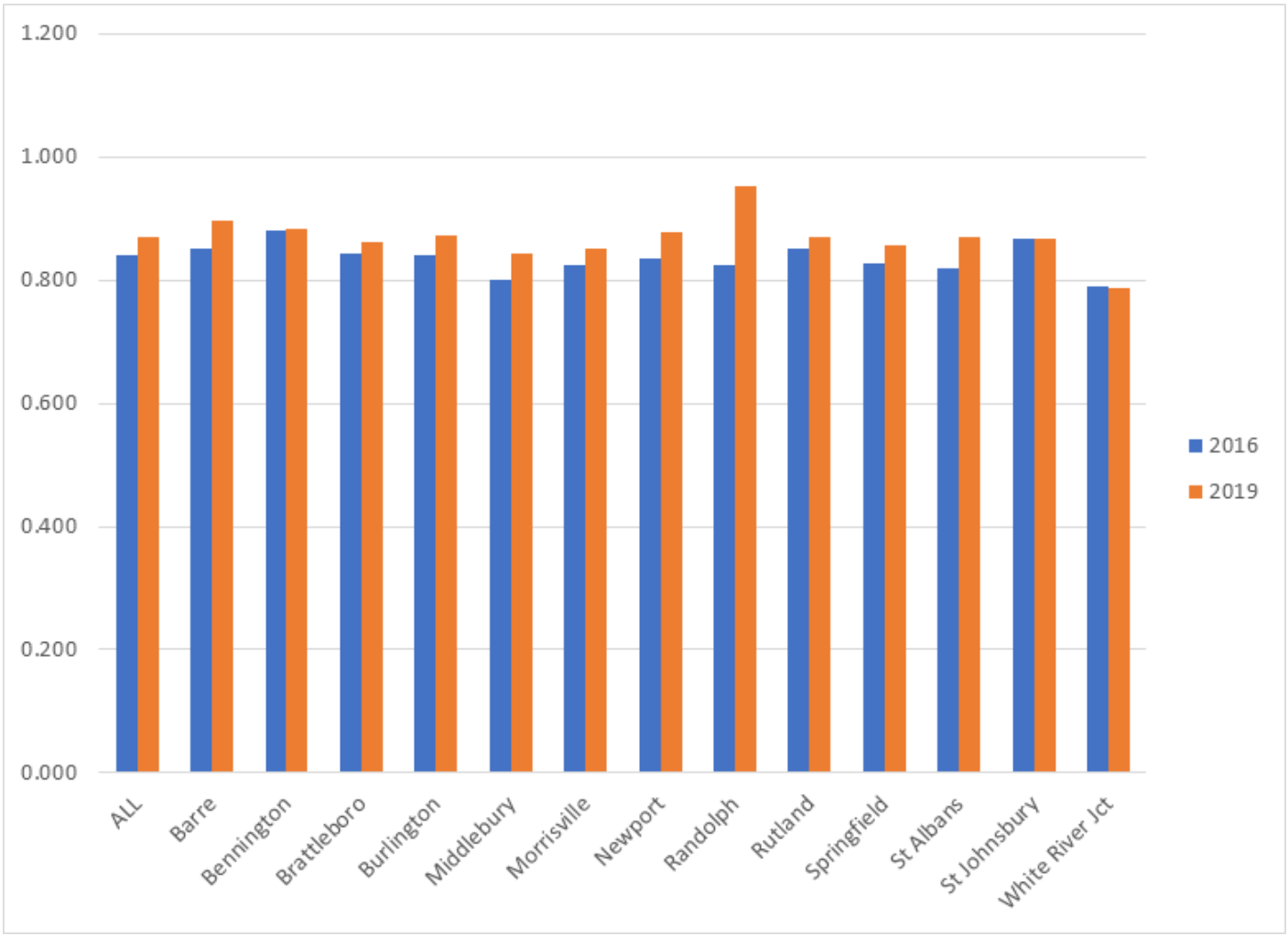


Figure 30: NQF3489 HEDIS Emergency Department Visits for Mental Illness, With Follow-Up in 30 Days (FUA) (Proportion): *Total VHCURES (Excluding Self-Insured) Population*



Focus: Healthcare Utilization for Opioid Use Disorder Patients Who Received Hub & Spoke Medication-Assisted Treatment (MAT) Versus Those Who Received Only Other/Non-MAT Opioid Use Treatments

Please note that MAT and non-MAT opioid-use-disorder patient populations are likely not equivalent, given the degree of biased selection that produces the two groups.

Figure 31: Outpatient Emergency Department Visits / 1000 Member Years: *All-Payer Opioid Use Disorder (OUD) Patients Who Received Medication-Assisted Treatment*

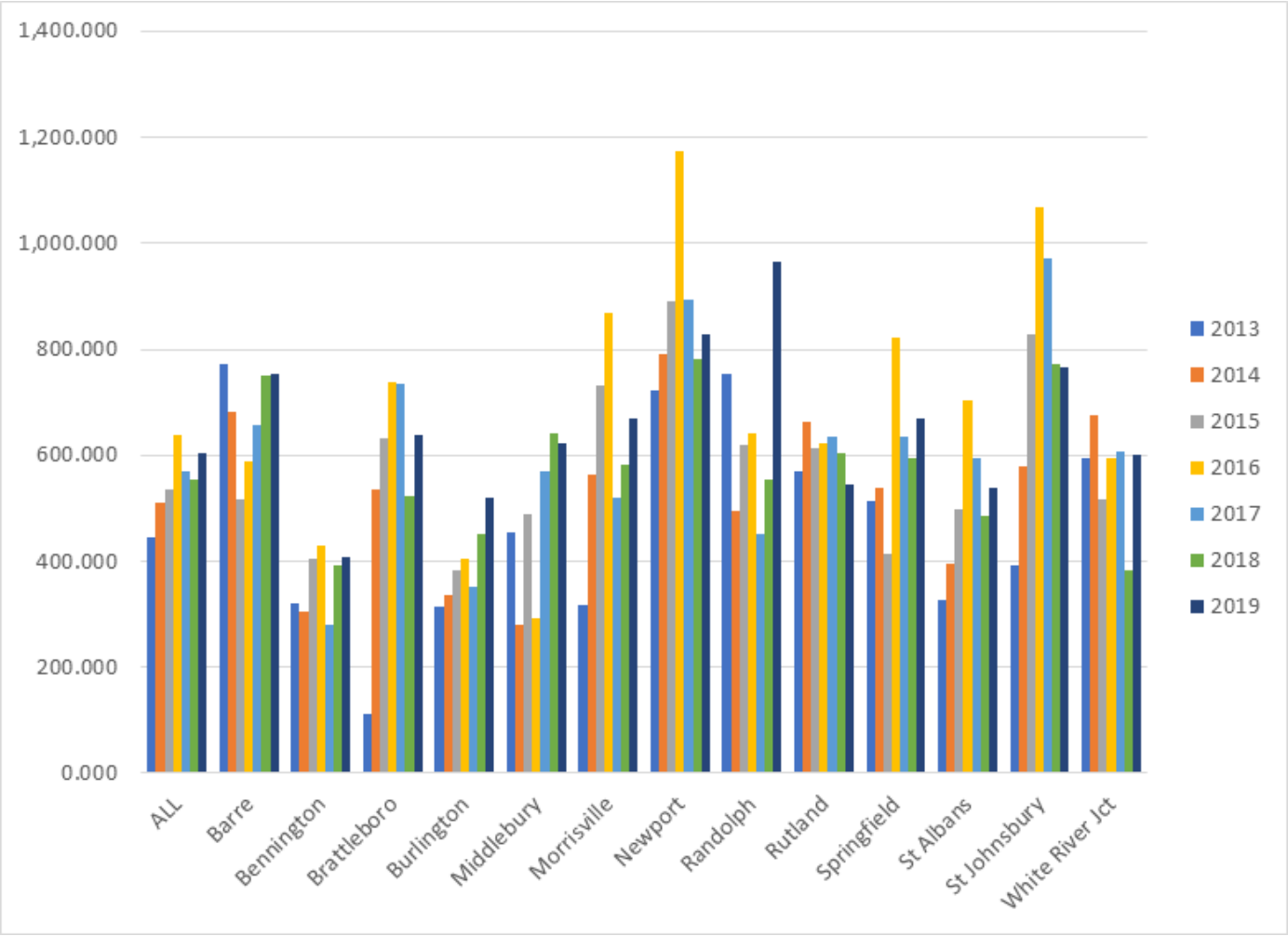


Figure 32: Outpatient Emergency Department Visits / 1000 Member Years: *All-Payer Opioid Use Disorder (OUD) Patients Who Received Only Other/Non-MAT Treatments*

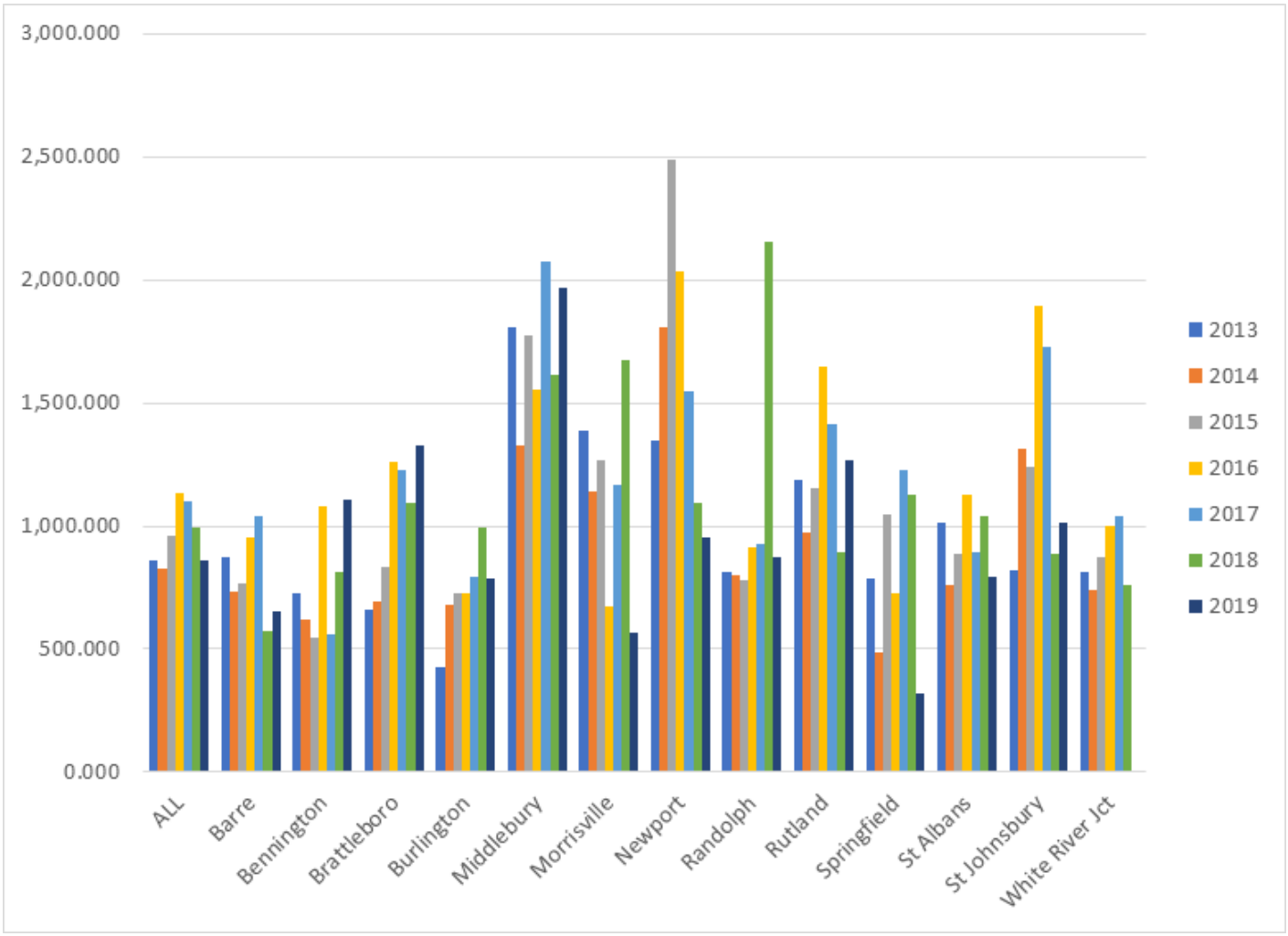


Figure 33: Inpatient Discharges / 1000 Member Years: *All-Payer Opioid Use Disorder (OUD) Patients Who Received Medication-Assisted Treatment*

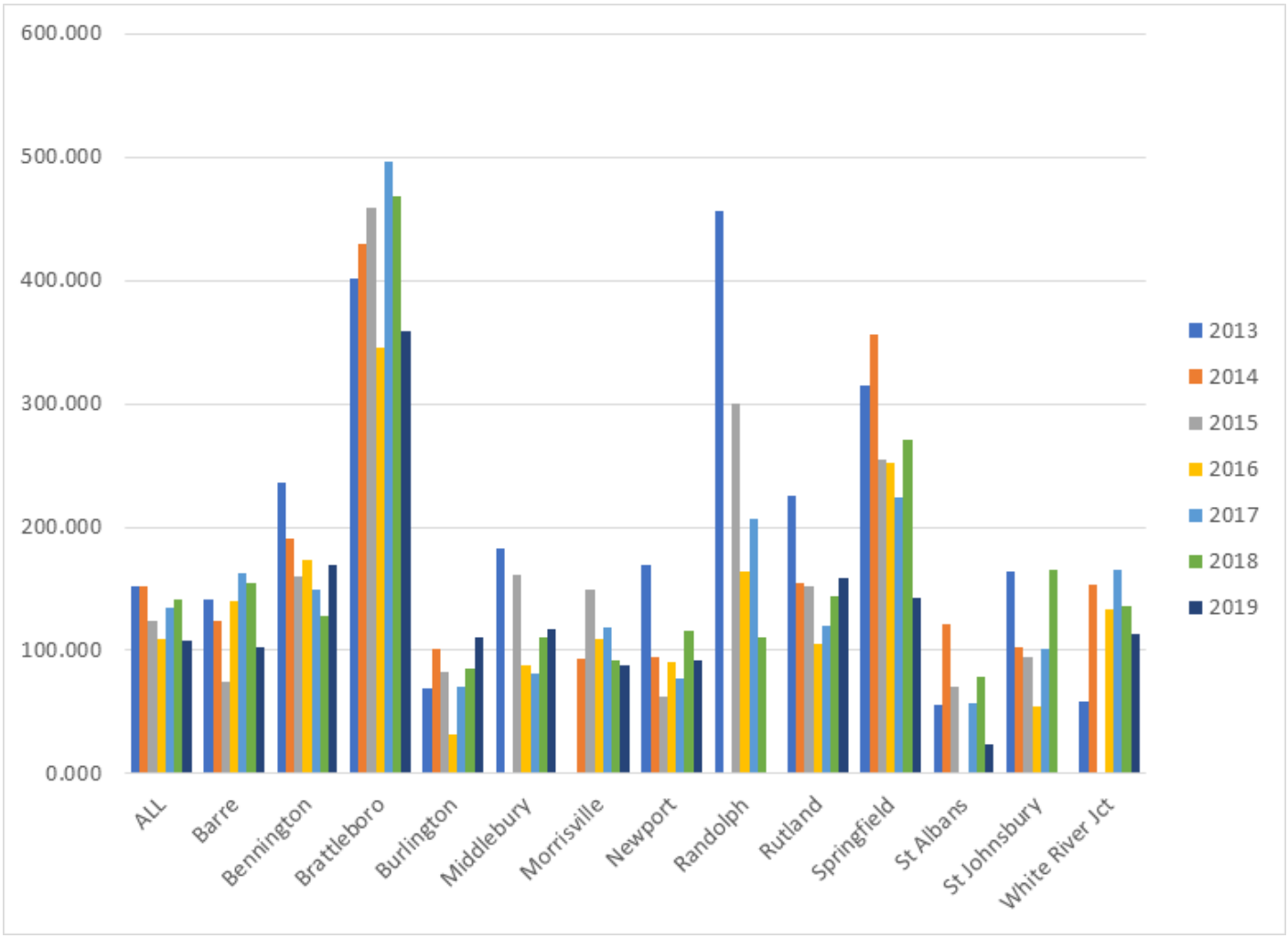
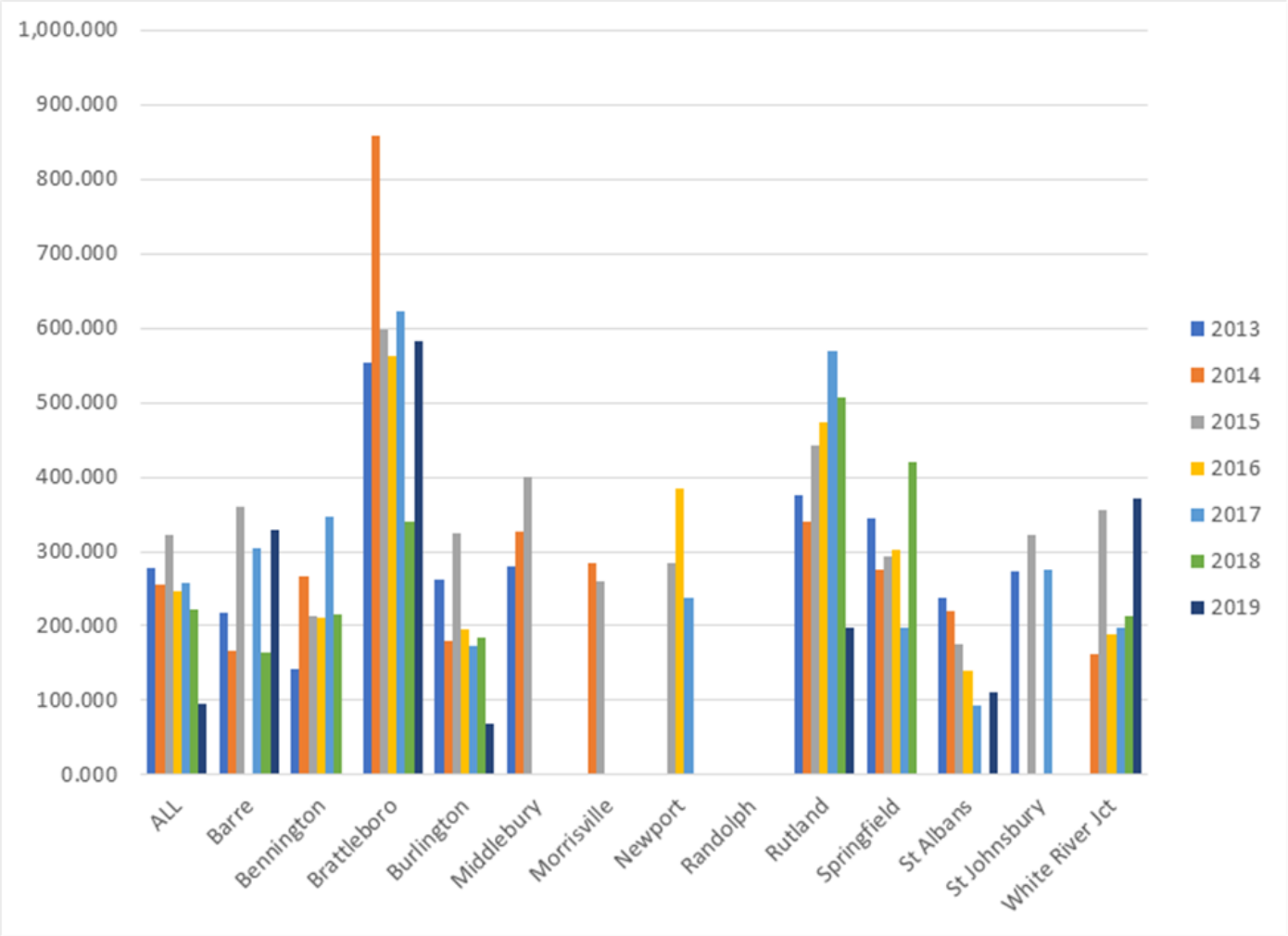


Figure 34: Inpatient Discharges / 1000 Member Years: *All-Payer Opioid Use Disorder (OUD) Patients Who Received Only Other/Non-MAT Treatments*



Patient Experience: 2020 Consumer Assessment of Healthcare Providers Survey (CAHPS)

Introduction

The Blueprint for Health (Blueprint) reports annually the patient experience of care as required by Vermont Statute. Since 2011, this task has been fulfilled through the administration of the CAHPS Clinician and Group Survey with Patient-Centered Medical Home (PCMH) questions included. The outcomes for this survey provide the broadest statewide look at patient experience of primary care in Vermont. The results are also used to support PCMH recognition by the National Committee for Quality Assurance (NCQA), and, most recently, as part of the quality reporting under payer contracts with OneCare Vermont under the All-Payer Accountable Care Organization Model.

Methods

The Department of Vermont Health Access (DVHA) since 2014 has contracted with DataStat Inc. to administer the survey. Staff from the Blueprint for Health central office work with DataStat, field staff such as Program Managers and Quality Improvement Facilitators, and ACO staff to recruit practices to participate in the survey. Once a practice has agreed to participate, that practice works directly with DataStat to set up an account through which lists of patients seen in the previous 6 months can be securely transmitted. Practices also submit logos and signatures to populate a letter accompanying the survey and inviting their patients to participate in completing and submitting the survey.

Once DataStat has the complete sampling frame (i.e., list of patients meeting eligibility criteria), OneCare Vermont provides a list of patients attributed to them under payer contracts. This allows DataStat to flag patients, and therefore deidentified outcomes, for ACO-level reports. In the next step, DataStat picks a random sample to which the introductory letter and survey will be mailed. In the last three years, DataStat, at the request of Blueprint and OneCare Vermont, has oversampled ACO-attributed patients (meaning the final sample has a higher proportion of ACO attributed patients than the original sample frame) to ensure sufficient number of responses for ACO quality measures. With the survey sample identified, two surveys are sent out: one to pediatric patients (to be filled out by the parent or guardian) and another to adult patients. Pediatric practices generally only send the pediatric survey, internal or general medicine practices generally only send the adult survey, and family practices generally send both the adult and pediatric surveys. The minimum number of patients for a practices survey sample is 100. Surveys are sent in two waves: the initial survey to everyone and a follow-up survey to those that did not respond to the first mailing.

Once the response window closes, DataStat removes any protected health information as specified in 45 CFR §160.103, compiles aggregated outcomes for each participating practice, and provides that practices with a report. Statewide data deidentified at the response-level is provided to Blueprint for Health central office staff. Blueprint staff then calculate the statewide, ACO-attributed, and hospital service area (HSA)-level outcomes. ACO outcomes are distributed to OneCare Vermont and payers.

Results

The number of practices that participated in the 2020 survey was 120, which is a decrease from 121 practices in 2019 and an increase from 108 practices in 2018. The number of surveys that were fielded were 50,162 with 8,969 adults and 1,601 pediatric patients responding. The combined response rate was 21.1%. The following graphs show the combined adult and pediatric responses for the composite measures, broken out by HSA.

Outcomes for the CG-CAHPS survey are often presented through composite measures, which represent the combined results for a group of related questions in the survey. The topics by which questions are grouped include:

- Access to Care
- Communication between provider and patient
- Coordination of Care

- Information about the practice and appointments
- How helpful and courteous the office staff were
- How the Provider Engaged the Patient in their Care (Self-Management)
- Access to Specialty Care

A full report including the survey questions for each composite above and results from the 2020 patient experience survey is available at:
https://blueprintforhealth.vermont.gov/sites/bfh/files/doc_library/2020PatientExperienceWrite-up-final.pdf

Presented below is a detailed look at two of the above-listed composites, Access to Care and Self-Management, followed by all the composite measures for both the state over four years (2017-2020) and in relation to the region and country for 2019.

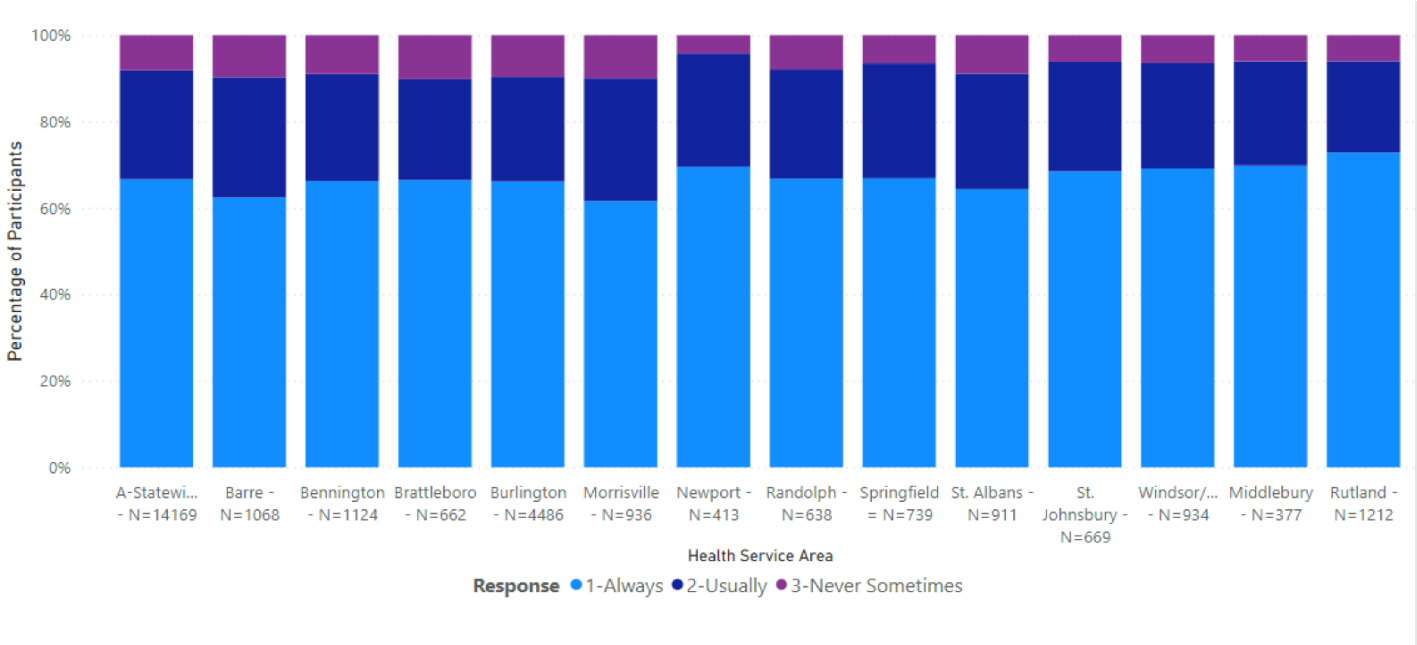
Access to Care

The first composite, Access to Care, focuses on how readily patients were able to receive needed care and includes the following questions, regarding the last 6 months:

- When you contacted this provider's office to get an appointment for care you **needed right away**, how often did you get an appointment as soon as you needed?
- When you made an appointment for a **check-up or routine care** with this provider, how often did you get an appointment as soon as you needed?
- When you contacted this provider's office during regular office hours, how often did you get an answer to your medical questions that **same day**?

Figure 35 below shows that the proportion who responded "Always" ranged from 62% (Morrisville) to 73% (Rutland), with the State average at 67%

Figure 35: Access to Care Composite CY2020



Self-Management

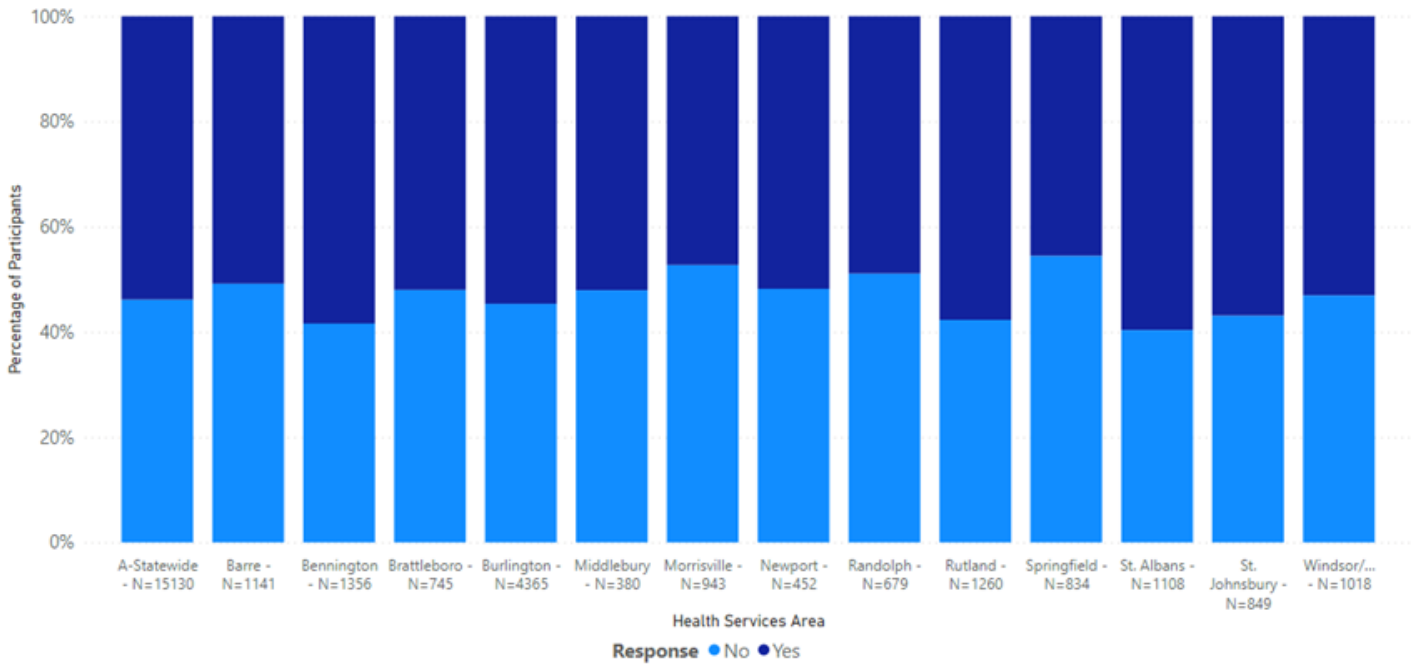
The Self-Management Composite focuses on how the provider engaged the patient in his or her care. The composite included the following questions, regarding the last 6 months:

• Did someone from this provider's office talk with you about **specific goals** for **your health**?

• Did someone from this provider's office ask you if there are things that **make it hard** for you to take care of **your health**?

Figure 36 below shows that the proportion who responded "Yes" ranged from 46% (Springfield) to 58% (Bennington) with a statewide average of 54%.

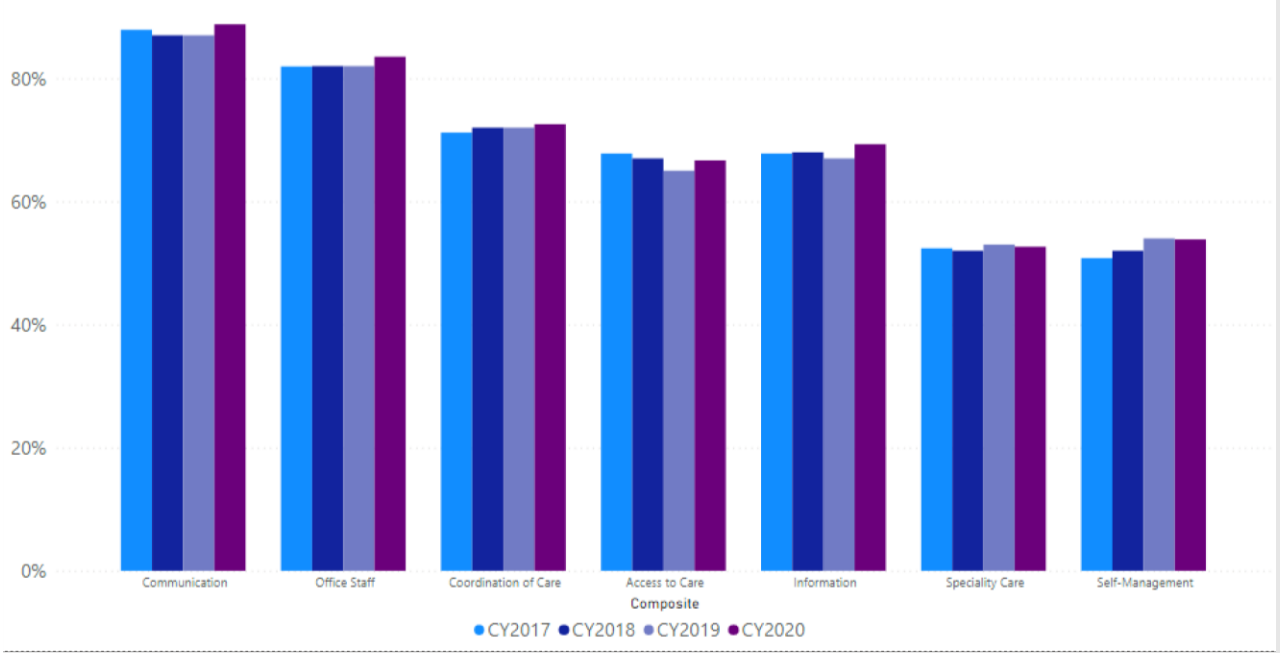
Figure 36: Self-Management Composite CY2020



Trending Over Time: Vermont Composite Results for 2017 - 2020

Figure 7 below shows the statewide performance in each of the composite over the last four years. Earlier years were omitted due to the changes in the survey that occurred prior to the 2017 survey year. There appears to be a slight increase over the years in the Communication, Office Staff, Coordination of Care, Information, and Self-Management composites. The Access to Care and Specialty Care appear to remain constant.

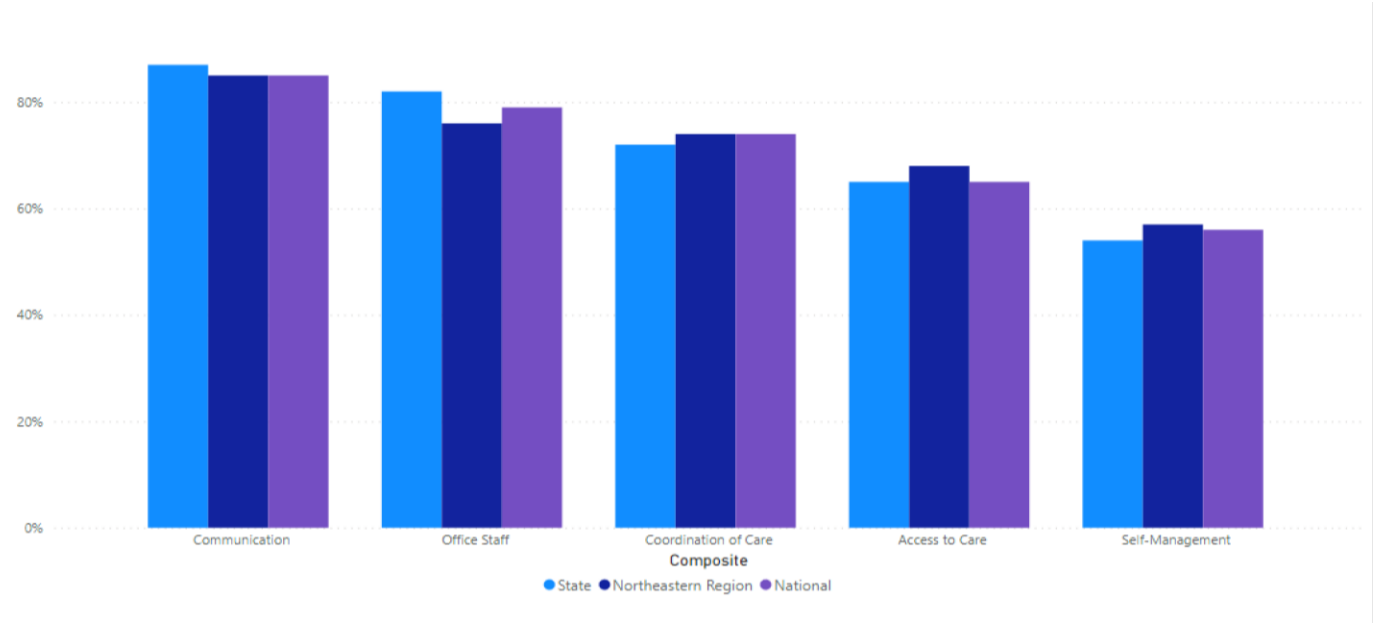
Figure 37: Statewide Composites - Trending Over Time (% Answered Always)



Comparison to National & Regional Benchmarks

Finally, this report reviews Vermont's 2019 performance to the national benchmarks for 2019 (the most recent year for which the benchmarks are available). Figure 8 below shows that for Communication and Office Staff, Vermont appears be higher than the national and regional averages. Coordination of Care and Self-Management composites are slightly lower. Figure 7, however, shows there may have been subtle improvement over time for Vermont in these same measures. For the Access to Care composite Vermont's data is equal to the national average but lower than the regional data. Relative to the Vermont's neighbors, there is room for improvement in the Coordination of Care, Access to Care and Self-Management composites.

Figure 38: How does Vermont compare? CY2019 Response (Answered Always)



Health Service Areas (HSAs) At-a-Glance

Barre Health Service Area

Program Manager: Michelle Gilmour

Barre by the Numbers

28,031	Blueprint Practices Patient Attribution
13.7	Community Health Team staff full time equivalents (FTEs)
6.0	Spoke staff FTEs
1.5	Women's Health Initiative staff FTEs
15	Self-management workshops held
81	Self-management workshop graduates
18,000	Community Health Team encounters
236	Patients served in area Spokes (Medicaid only)

Barre Community Health Team

Barre Blueprint Practices Blueprint and ACO Payer Participation

Parent Organization	Practice Site Name	ACO Participation						
		medicare	medicaid	bcbs	mvp	PCMH	WHI	Spoke
BAART	BAART-Berlin							X
Central Vermont Medical Center	CVMC Adult Primary Care - Barre	X	X	X	X	X		X
Central Vermont Medical Center	CVMC Family Medicine - Berlin	X	X	X	X	X		X
Central Vermont Medical Center	CVMC Family Medicine - Mad River	X	X	X	X	X		
Central Vermont Medical Center	CVMC Family Medicine - Waterbury	X	X	X	X	X		X
Central Vermont Medical Center	CVMC Integrative Family Medicine - Montpelier	X	X	X	X	X		X
Central Vermont Medical Center	CVMC Pediatric Primary Care - Berlin	X	X	X	X	X		
Central Vermont Medical Center	Green Mountain Family Practice	X	X	X	X	X		X
Central Vermont Medical Center	CVMC-Women's Health	X	X	X	X		X	
Independent Practice	Tree of Life Medicine					X		
The Plainfield Health Center	The Health Center	X	X	X	X	X		
Treatment Associates	Treatment Associates-Montpelier							X
University of Vermont Medical Center	UVMHN CVMC Family Medicine - Berlin - Main Campus	X	X	X	X	X	X	X

Community Health Team

The CHT in our HSA is decentralized with a current team of 22 working within local PCMHs, Women's Health, with the local substance use treatment centers and others. CVMC employed three full time RNs to specialize in ACO Care Coordination. Two ACO RNs are embedded into primary care and one in cardiology focusing on improving quality care, reducing costs, admissions, readmissions, telemonitoring and ED utilization. Specifically, the ACO RN is an active part of the care team for shared patient identification, attending staff meetings, huddles, and care team conferences. The project identified patients with diabetes, COPD, and/or asthma classified as high or very high risk by ACO attribution.

Accomplishments

The CVMC MAT team has been central to efforts to make harm reduction kits available in Central Vermont. Working with the CVMC Emergency Department, funds were secured and used to purchase supplies in addition to what is available from the Vermont Department of Health. These kits were made available first in our emergency department when staff identified high risk circumstances. It has since been being made available to primary care practices through the MAT staff who have been encouraging the practices to have them readily available for wider distribution as overdose rates continue to climb.

Central Vermont continued to excel in the implementation of 25% more self-management classes with an increase of 40% in successfully completed participants. Several factors led to this increase: leveraging leaders across that state to run classes virtually, providing variable options/times for classes for all patients who lead busy lives the ability to participate, and repeat participants who join other topics that would have been limited based on traditional delivery methods.

COVID-19 Response

In response to COVID-19 many of our CHT services have transitioned to telemedicine, which will continue to be a viable format into the future. The CHT has also been involved in outreach to identify patients in our community that may need vaccination and boosters.

Quality Improvement initiatives

Our COPD collaborative has grown to include a Pulmonologist, clinic RN, ACO RN and CHT leadership to manage high risk patients and connect them with care coordination.

Women's health initiative made substantial headway in getting the One Key Question added into the Electronic Health Record. Efforts continue to ensure collaboration across the UVMHN to improve standardization in processes and protocols.

Collaboration with multiple community partners (WCMH, CVHHH, CVCOA, CVMC, SASH) to identify high risk populations and provide wrap around supports services.

Central Vermont Prevention Coalition (previously WSARP) has successfully completed its first-year implementation of its HRSA RCORP grant, which aims to improve access to treatment, reduce overdose and enhance prevention and recovery efforts across the region.

Future Goals

In addition to continuing the work underway our team will be focusing on standardization. We aim to build a more robust structure for monitoring the services being rendered and ensuring the same access to resources exists across the HSA. Enhanced structure will positively impact CHT resource utilization, decrease duplication and allow us to be more strategic in matching the services to the community need. CVMC is creating disease specific assessment protocols for the management of diabetes, COPD, and asthma to be used across primary care. Measurable outcomes include identifying and overcoming barriers to accessing care, advance community agency collaboration, increase percentage of patients with advance care plan and increase patient and care team members' satisfaction. The first six-month outcomes data set is anticipated in January 2022.

Bennington Health Service Area

Program Manager: Caitlin Tilley

Bennington by the Numbers

20,386	Blueprint Practices Patient Attribution
7.7	Community Health Team staff full time equivalents (FTEs)
6.0	Spoke staff FTEs
0.5	Women's Health Initiative staff FTEs
2	Self-management workshops held
23	Self-management workshop graduates
13,453	Community Health Team encounters
406	Patients served in area Spokes (Medicaid only)

Bennington Community Health Team

Bennington Blueprint Practices Blueprint and ACO Payer Participation

Parent Organization	Practice Site Name	ACO Participation				PCMH	WHI	Spoke
		medicare	medicaid	bcbs	mvp			
Independent Practice	Avery Wood; MD	X	X	X	X	X	X	
Independent Practice	Battenkill Valley Health Center					X		X
Independent Practice	Brookside Pediatrics and Adolescent Medicine					X	X	
Independent Practice	Eric Seyferth; MD	X	X	X	X	X		
Independent Practice	Green Mountain Pediatrics		X	X	X	X		
Independent Practice	Keith Michl; MD					X		
Independent Practice	Shaftsbury Medical Associates	X	X	X	X	X		X
Primary Care Health Partners	Mount Anthony Primary Care	X	X	X	X	X		X
SaVida	SaVida-Bennington							X
Southwestern Vermont Health Care	SVMC Deerfield Valley Campus	X	X	X	X	X		X
Southwestern Vermont Health Care	SVMC Internal Medicine	X	X	X	X	X		
Southwestern Vermont Health Care	SVMC Northshire Campus	X	X	X	X	X		
Southwestern Vermont Health Care	SVMC Pediatrics	X	X	X	X	X		
Southwestern Vermont Health Care	SVMC-OB GYN	X	X	X	X		X	
Southwestern Vermont Health Care	SVMC Pownal Campus	X	X	X	X	X		

Community Health Team

The Bennington CHT is primarily comprised of highly skilled team members who are embedded directly into the 13 participating practices in our area. 12 practices receive embedded case management support to some capacity at this time. We are actively partnered with our designated mental health agency, United Counseling Services, to provide embedded behavioral health resources as well. Registered Dietician and Social Work supports in the Bennington HSA are more centralized with one person receiving referrals across the entire HSA. The CHT team members collaborate across agencies and disciplines to ensure effective care coordination of routine and complex care, specifically around care transitions.

COVID-19 Response

COVID-19 has certainly changed the way care is provided in our area. Throughout the various phases of the pandemic, our CHT has been flexible in working to meet patients where they are and provide support in a way that feels comfortable and safe for them at that time. Virtual and telephone visits have become part of our "new normal" allowing for an increase in successful connection with patients during a time of isolation. COVID-19 has highlighted the impact that social determinants of health have within our community and has fostered an increase in interagency collaboration and communication with key partners.

Accomplishments/Quality Improvement Initiatives

The Bennington CHT has consistently prioritized positive patient outcomes during an extremely challenging year. There have been many success stories shared by colleagues that highlight the impact that patient-centered care can have when actively engaging the patient and family as a key team member. From high-risk outreach around transitions of care to coordinating testing and vaccination for individuals and families, this team has demonstrated that there is not much they cannot achieve – including three team members obtaining the Certified Case Manager (CCM) certification. The Bennington CHT continued to move forward with strategizing how to successfully participate in OneCare VT's care coordination efforts and are actively participating in the planning process for changes that are expected in 2022.

The addition of a full-time social work team member to the CHT has been immensely beneficial, allowing additional support and a collaborative resource for team members to learn and share ideas when navigating challenging cases. In addition, a community health navigator was able to join the Spoke team to support the complex needs around insurance needs, housing insecurity, and financial challenges that impact this population.

The Spoke team has become increasingly involved in closing the gap in care transitions for patients receiving care in the ED or inpatient setting. Because patients new to MAT treatment or recently discharged from an inpatient setting are vulnerable, care coordination from trained nurses and therapists is essential to their recovery. They also work closely with colleagues in the community to provide targeting education about substance use disorders, how to effectively manage post-surgical pain for MAT clients, and to improve understanding of the work they do on a daily basis.

Additionally, our local emergency department (ED) team is a strong advocate of rapid access to medication (RAM) assisted treatment and supports patients' recovery in collaboration with Turning Point of Bennington and the Spoke team. Because of this partnership, 100% of patients requesting MAT have an appointment within three days (per state quality recommendations), and in most cases, within twenty-four hours.

Across all aspects of the care continuum, we are actively working to increase understanding of the immense support that integrated Blueprint services can provide within the HSA and ensuring that our colleagues understand the role of team members to avoid duplicative services when the resource may already exist.

Our teams working with the pediatric population have partnered with the school district and UCS to connect monthly to improve communication between teams and strategize how to improve mental health care for the youth in our community. Members from all three key agencies have been collaboratively exploring and implementing innovative ways of stabilizing students of all ages in an attempt to decrease ED utilization and improve follow-up care and resource connection for high-risk youth.

Despite multiple transitions in the WHI programming for the HSA, data collection around screening efforts have streamlined and we have seen an increase in engagement of practices with LARC insertion over the last year. The team will continue to seek active engagement in achieving WHI goals at each participating practice.

The Bennington Community Collaborative and monthly Care Coordination meetings have been an invaluable avenue to ensure that our Blueprint team and key community stakeholders remain connected and working towards achieving goals around shared care planning, improved collaboration and communication and eliminating duplication of services where possible. Work has been done to ensure that the right people are at the table for these meetings to facilitate valuable use of time across agencies. While there is still some strategic planning happening for the Bennington Community Collaborative happening, it is refreshing to have such a strong group of individuals come together to identify ways to improve the community from all angles.

Future Goals

Unfortunately, Bennington continues to see an increase in overdose deaths in 2021 and teams are actively engaged in work to reverse this trend. The Bennington HSA was fortunate to receive funding in 2021 for the Community Action Grant, and that funding will continue into 2022. The Community Action Grant aims to prioritize overdose prevention training, linkage to care, and enhancement of first responder engagement as key strategies to address the impact that substance use has had in our community. In coordination with the Opioid Response Team, these two initiatives will facilitate the development of a thriving, diverse recovery community in Bennington County in an attempt to increase accessibility to recovery options in our area. Under new direction, we are excited to reinvigorate these initiatives to increase the positive impact the Community Action Grant will have in Bennington.

Brattleboro Health Service Area

Program Manager: Rebecca Burns

Brattleboro by the Numbers

13,304	Blueprint Practices Patient Attribution
8.7	Community Health Team staff full time equivalents (FTEs)
3.5	Spoke staff FTEs
0.6	Women's Health Initiative staff FTEs
31	Self-management workshops held
157	Self-management workshop graduates
4,640	Community Health Team encounters
180	Patients served in area Spokes (Medicaid only)

Brattleboro Community Health Team

Brattleboro Blueprint Practices Blueprint and ACO Participation

Parent Organization	Practice Site Name	ACO Participation						
		medicare	medicaid	bcbs	mvp	PCMH	WHI	Spoke
Brattleboro Memorial Hospital / SVHSC	Brattleboro Family Medicine	X	X	X	X	X		
Brattleboro Memorial Hospital / SVHSC	Brattleboro Internal Medicine	X	X	X	X	X		
Brattleboro Memorial Hospital / SVHSC	Maplewood Family Practice	X	X	X	X	X		
Brattleboro Memorial Hospital / SVHSC	Putney Family Healthcare	X	X	X	X	X		
Brattleboro Memorial Hospital / SVHSC	Windham Family Practice	X	X	X	X	X		
Brattleboro Memorial Hospital / SVHSC	Four Seasons OB/GYN and Midwifery	X	X	X	X		x	
Grace Cottage Hospital	Grace Cottage Family Health					X		
Independent Practice	Brattleboro Retreat							X
Primary Care Health Partners	Brattleboro Primary Care-Pediatric Medicine	X	X	X	X	X		

Community Health Team

Brattleboro Memorial Hospital, the Blueprint administrative entity, has a hybrid Community Health Team with both a centralized model along with some pass-through funds to different primary care practices. Our CHT funds support RN care coordinators, Diabetic educators, Health Coach, Social Worker, Referral Specialist, Registered Dietician and a Pediatric Care Coordinator. A Rise VT Program coordinator and a Community Health Nurse embedded in our local shelter for folks experiencing homelessness within the community.

COVID-19 Response

The Community Health Team continues to assist with the COVID-19 response in our community by assisting with vaccination efforts. We continue to utilize video visits and phone visits to deliver care. We are planning to continue these offerings 'post pandemic' as they allow for increased access to care for people.

Accomplishments

We have been very successful with increased access to our Self-Management programs. Will the offering of statewide and virtual, people were able to participate when it worked for them. The CHT also continued to be able to support people through our services at no cost to them which has been instrumental for people experiencing financial difficulties. We completed our Community Health Needs Assessment (CHNA) and received double the survey responses that we received the previous year. This was a huge accomplishment. Continued support of COVID-19 vaccination efforts has also been an area of accomplishment.

Our CHT lead facilitates a monthly care coordination meeting to discuss needs and resources in our community. Participation has increased when moved to a virtual platform. We continued care coordination efforts in our HSA as well.

The Accountable Communities for Health (ACH) has continued with a focus on addressing Mental Health resources in our community. Gaining momentum has been a challenge over the past year, as COVID-19 response and significant staffing challenges have diminished the availability of all partners to do this work.

Healthworks, a collaboration between Brattleboro Memorial Hospital, Brattleboro Retreat, Health Care and Rehabilitation Services (HCRS) and Groundworks continues to embed clinical staff into the shelter to assist folks who are unhoused in our community with healthcare, including mental health care. The team is currently in the process of seeking funding to expand the program. The Healthworks nurse also took the lead in vaccinating unhoused population.

Quality Improvement initiatives

Our QI facilitator worked closely with all PCMH practices to achieve continuing recognition. Her support is instrumental in this process. Our QI facilitator is integrated in our monthly meetings supporting the Women's Health Initiative and provides continuous framework and information to improve care through SBINS screening and increase access to LARC. Improving quality of care is a goal of this QI project.

Future Goals

We continue to hold care coordination meetings, internally and in the community. We are currently exploring ways to continue coordinating care with the change in the requirements for OneCare reporting and use of Care Navigator. We do have care coordinators in each primary care practice who will continue to support the needs of our population. More to come on how the program will evolve to continue to support care team participation and shared care planning.

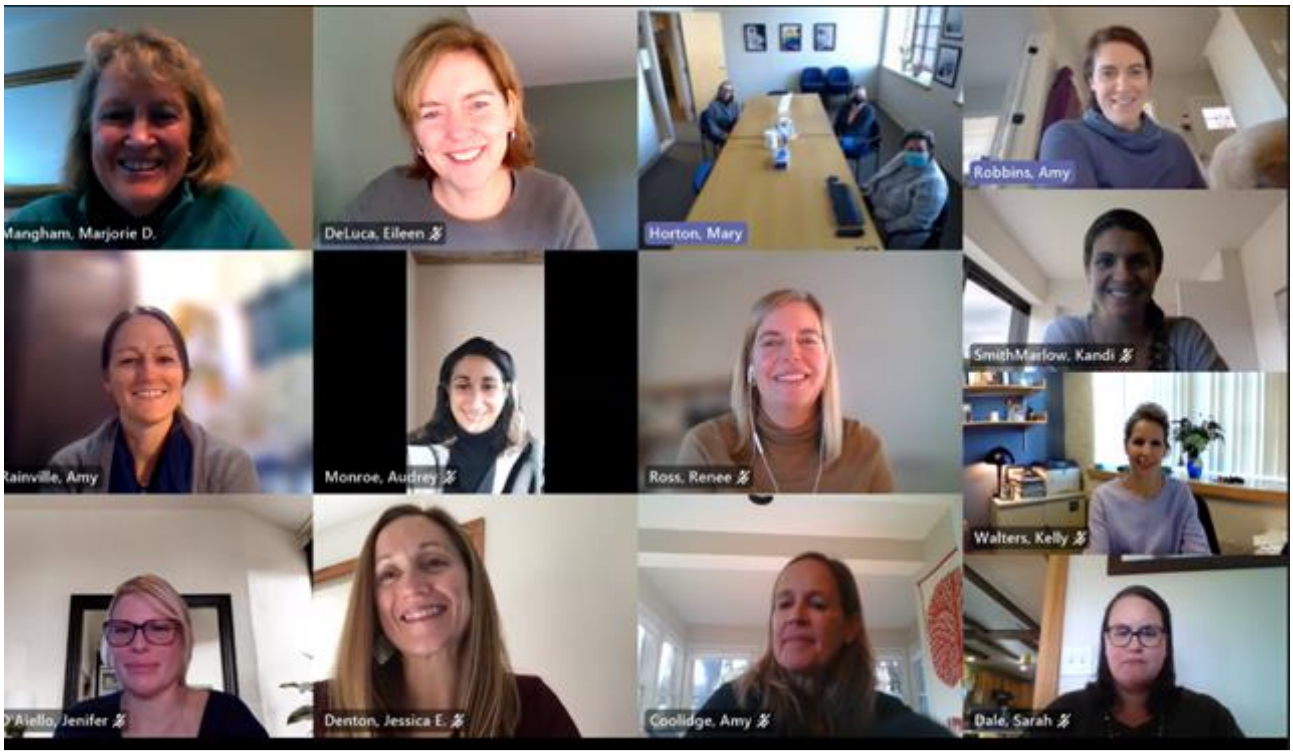
We will continue to work with the practices around chronic disease management through our care coordinators, health coach and registered dieticians. We will also be exploring other grant opportunities to support the work around chronic disease management and prevention. The CHT/ Brattleboro Memorial Hospital (BMH) continue to be a member of the Consortium on Substance Use which is focused on reducing death by overdose. We will also continue to work with the Accountable Communities for Health (ACH). Overdose and suicide are also part of that work. Accessing specialty services and primary care services is part of our daily workflow within our CHT. We will be looking to focus on these 4 areas going forward.

Burlington Health Service Area

Program Manager: Kerry Sullivan

Burlington by the Numbers

88,394	Blueprint Practices Patient Attribution
37.9	Community Health Team staff full time equivalents (FTEs)
22.2	Spoke staff FTEs
2	Women's Health Initiative staff FTEs
5	Self-management workshops held
32	Self-management workshop graduates
30,550	Community Health Team encounters
1,132	Patients served in area Spokes (Medicaid only)



Burlington Community Health Team

Burlington Blueprint Practices Blueprint and ACO Participation

Parent Organization	Practice Site Name	ACO Participation						
		medicare	medicaid	bcbs	mvp	PCMH	WHI	Spoke
Community Health Centers of Burlington	Champlain Islands Health Center	X	X	X	X	X		
Community Health Centers of Burlington	Good Health	X	X	X	X	X		
Community Health Centers of Burlington	Pearl Street Youth Health Center	X	X	X	X	X		
Community Health Centers of Burlington	Riverside Health Center	X	X	X	X	X	X	X
Community Health Centers of Burlington	Safe Harbor Health Center	X	X	X	X	X	X	
Community Health Centers of Burlington	South End Health Center	X	X	X	X	X	X	X
Community Health Centers of Burlington	Winooski Family Health	X	X	X	X	X	X	
Evergreen Family Health	Alder Brook Family Health					X		X
Evergreen Family Health	Charlotte Health Center					X		
Evergreen Family Health	Evergreen Family Health					X		X
Howard Center	Howard Center-Burlington							X
Howard Center	Pine Street Counselign Center							X
Independent Practice	Affiliates in OB/GYN						X	X
Independent Practice	Alicia Cunningham, MD							X
Independent Practice	Champlain Center for Natural Medicine		X	X	X	X	X	
Independent Practice	Champlain Obstetrics and Gynecology						X	
Independent Practice	Dr. Hebert	X	X	X	X	X		X
Independent Practice	Essex Pediatrics	X	X	X	X	X		
Independent Practice	Frank Landry MD PLC					X		
Independent Practice	Gene Moore	X	X	X	X	X		
Independent Practice	Green Mountain Internal Medicine; PLC	X	X	X	X	X		X
Independent Practice	Lakeside Pediatrics; PLLC		X	X	X	X		
Independent Practice	Mountain View Natural Medicine - Colchester		X	X	X	X		
Independent Practice	Mountain View Natural Medicine - So. Burlington		X	X	X	X		
Independent Practice	Pediatric Medicine		X	X	X	X		
Independent Practice	Richmond Family Medicine	X	X	X	X	X		
Independent Practice	Thomas Chittenden Health Care (TCHC)	X	X	X	X	X		X
Independent Practice	Vermont Integrative and Naturopathic Medicine (JMS; PLC)		X	X	X	X		
Phoenix Houses of New England, Inc.	Phoenix House-Burlington							X
Primary Care Health Partners	Timber Lane Milton Peds	X	X	X	X	X		
Primary Care Health Partners	Timber Lane North Peds	X	X	X	X	X		
Primary Care Health Partners	Timber Lane Pediatrics	X	X	X	X	X		
SaVida	SaVida-Colchester							X
University of Vermont Medical Center	Appletree Bay Primary Care	X	X	X	X	X		X
University of Vermont Medical Center	UVMMC Adult Primary Care - Burlington	X	X	X	X	X		X
University of Vermont Medical Center	UVMMC Adult Primary Care - Essex	X	X	X	X	X		X
University of Vermont Medical Center	UVMMC Adult Primary Care - South Burlington	X	X	X	X	X		X
University of Vermont Medical Center	UVMMC Adult Primary Care - Williston	X	X	X	X	X		X
University of Vermont Medical Center	UVMMC Obstetrics and Midwifery	X	X	X	X		X	X
University of Vermont Medical Center	UVMMC Family Medicine - Colchester	X	X	X	X	X	X	X
University of Vermont Medical Center	UVMMC Family Medicine - Hinesburg	X	X	X	X	X	X	X
University of Vermont Medical Center	UVMMC Family Medicine - Milton	X	X	X	X	X	X	X
University of Vermont Medical Center	UVMMC Family Medicine - South Burlington	X	X	X	X	X	X	X
University of Vermont Medical Center	UVMMC Pediatric Primary Care - Burlington	X	X	X	X	X		X
University of Vermont Medical Center	UVMMC Pediatric Primary Care - Williston	X	X	X	X	X		X

Community Health Team

The Burlington HSA Community Health Team has been deployed to meet the needs of the various types of primary care practices in our community. There are 3 categories into which our HSA breaks down- our large FQHC (Community Health Centers of Burlington), our large network of independently owned primary care practices, and a large network of hospital owned primary care practices. Our CHT is both hired through our Blueprint Administrative entity and deployed within practices, and some practices opt for pass through of the funding so they can hire and deploy staff in a way that best suits their practice needs. Pre-pandemic, the larger CHT would meet twice a year for trainings, information sharing, and finding ways to connect. In the current state we have found ways to offer virtual trainings and share information, but there is not one centralized team.

CHT roles vary from social worker, nurse, care coordinator, health coach, referral coordinator, to even supporting specialties like acupuncture, and more all to support the PCMH standards of care.

Below is feedback directly from practices about the changes they have seen and wish to continue and future goals

COVID-19 Response

- During the pandemic, mental health issues increased significantly. Having an embedded social worker who was able to provide counseling services via telehealth was in invaluable resource to our patients. Telehealth visits continue today for those patients that need it.
- We started doing Teleheath visits (THV). We will continue THV for many of our mental health, controlled substances, Medication Assisted Treatment and attention deficit disorder visits. It is much easier for the patient and since the clinician doesn't really need hands on for these visits, THV works well.
- Through telehealth care team members at the school and community level (Howard Services) can meet to coordinate care between office, counselors and school team members. Most often the physician is able to participate via a zoom conference. This has allowed input from the PCP to management with a minimal impact on the schedule, as no travel time out of the office is required.

Accomplishments

- We were able to provide both primary care and mental health services to our patients without interruption by both telehealth and in-person service.
- We were able to grow our practice to bring on 2 new providers and we have seen an increase in our number of patients. We kept all our MAT patients having visits and staying on track without any relapses, that we are aware of, during this pandemic.
- Televisits and zoom meetings are now much more widely accepted as a means of communication, initially as a result of limiting in person exposure. There are certainly benefits to this for patients and for providers to offer input to group (and community) meetings.
- Since the start of the pandemic, our office has remained open to patients and I (social worker) have continued to serve patients in office, virtually and in the community when needed. With a lot of providers having to move to full remote, many families really appreciated the additional support!

The Chittenden Accountable Community for Health (CACH) has continued to focus on robust work with community partners, PCMH's and the BP team. Their focus as the Core Team, and 3 Action Teams on Social Connectedness, Reducing Stigma, and Screening and Intervention as ways to decrease the suicide in our community aligns with APM goals. Outcomes from their work include trainings on screenings and interventions, capturing data in EHR's to support data sharing, trialing a screening tool with SASH, identifying key community partners to evaluate data and introduce a survey tool to National Guard members and families.

Quality Improvement Initiatives

Community Health Centers of Burlington (CHCB) and Appletree Bay have been participating in the Vermont Department of Health's Chronic Disease Prevention Initiative. Focusing on uncontrolled diabetes and hypertension. CHCB also works in partnership with Bi-State Primary Care Association and a Blueprint QI Facilitator to address continuous systems-level improvement to reduce the burden of chronic disease on Vermonters by supporting diabetes, prediabetes and hypertension identification, management, and control with referral to self-management and prevention programming.

This year we saw our independent practices work to increase Medicare Annual Wellness visits by offering the patient to be seen by a nurse. Independent practices also worked diligently to bring in patients overdue for needed service that had been missed due to the pandemic. Important measures included were depression screening, well child visits, overdue hypertensive and diabetes chronic care services. Many practices focused on offering extra flu clinics using inventive drive through techniques e.g., canopies to stay out of the elements.

Independent practices have started to focus on incorporating OneCare Vermont quality measures into quality improvement efforts with their Blueprint QI Facilitator.

Referral tracking and follow-up with specialist's care was severally impacted by COVID-19 and practices have worked hard on this care coordination effort, to ensure patient's needs were met.

Future Goals

- As we have been able to come back together as a group, we have re-introduced team meetings and are looking at more ways to include staff and providers; plus, each team meets in the morning before they start seeing their patients.
- We implemented huddles early in 2020 as well clinical lead medical assistants to help in planning the day for their clinic.
- All Provider meetings, QI projects; we are one of the few primary care practices that is accepting new patients. We have a robust referral department that does an excellent job getting referrals in and tracking them until closure.
- Opening up our practice to more patients, hiring a full-time social work and in early 2022 we will have a full time psychiatric APRN. We continue to look at maximizing protocols to improve the care we give to our patients.
- Continues to focus on identifying the clients and needs as early as possible to help connect families with appropriate services, including supporting parents of our clients to connect to appropriate services with their care team and when they may not be available.

Middlebury Health Service Area

Program Manager: Sylvie Choiniere

Middlebury by the Numbers

16,838	Blueprint Practices Patient Attribution
5.8	Community Health Team staff full time equivalents (FTEs)
3.4	Spoke staff FTEs
0.75	Women's Health Initiative staff FTEs
9	Self-management workshops held
56	Self-management workshop graduates
11,500	Community Health Team encounters
190	Patients served in area Spokes (Medicaid only)

Middlebury Community Health Team

Middlebury Blueprint Practices Blueprint and ACO Participation

Parent Organization	Practice Site Name	ACO Participation						
		medicare	medicaid	bcbs	mvp	PCMH	WHI	Spoke
Independent Practice	Middlebury Family Health Center	X	X	X	X	X		
Independent Practice	Mountain Health Center	X	X	X	X	X		X
Independent Practice	Rainbow Pediatrics					X		
Independent Practice	Vermont Natural Family Health - Salisbury		X	X	X	X		
Porter Medical Center	UVM Health Network Porter Medical Center Pediatric Primary Care	X	X	X	X	X		
Porter Medical Center	UVM Health Network Porter Medical Center Primary Care Brandon	X	X	X	X	X		
Porter Medical Center	UVM Health Network Porter Medical Center Primary Care Middlebury	X	X	X	X	X		
Porter Medical Center	UVM Health Network Porter Medical Center Women's Health	X	X	X	X		X	
Porter Medical Center	UVM Health Network Porter Medical Center Primary Care Vergennes	X	X	X	X	X		X
SaVida	SaVida-Vergennes							X

Community Health Team

The Community Health Team is comprised of Behavioral Health Specialists, Registered Dietitians and Care Coordinators. All of these free services are available to patients in each of the Patient-Centered Medical Homes in Addison County. There is a mix of full-time CHT staff hired by the administrative entity that support 2 or more practices, as well as individual practice staff funded through by administrative entity to devote a portion of their time for CHT services in their home practice. This model helps provide consistent care throughout the county and allows patients to know that whichever practice they are a part of, they are eligible for free CHT services. This wrap around model is valued and supported by our Primary Care Providers and Pediatricians to holistically support our patients in Addison County.

COVID-19 Response

During the COVID-19 pandemic, the CHT team shifted a portion of their work to support the PCP offices and reach out to patients that were at high-risk for COVID-19 and to those who had not been over the past year. There was an increase in CHT and MAT Behavioral Health staff referrals due to the stress of COVID-19, social isolation, burnout, and various factors that were impacting mental health. The MAT team increased outreach to patients who were at high-risk due to homelessness, substance use, and general stressors of COVID-19. Lastly, CHT staff stepped up and helped at various COVID-19 vaccine clinics hosted by both UVMHN Porter Hospital and VDH.

Accomplishments

The Community Health Action Team (CHAT) continuously met throughout the pandemic to maintain and expand community collaboration efforts. The group consists of various cross-sector organizations that provide direct service and support to individuals and families in Addison County. Although many of the meetings were focused on updates from the partners, it helped care managers better coordinate care and keep up with the new and adjusted resources in the community. This community also supported each other during a hard time and were able to share hardships, challenges, and ways in which they were able to overcome those or partner with others who could help fill gaps. This group remains strong and is hopeful to work towards future initiatives around trauma-informed care and work force development.

The collaboration between UVMHN Porter Primary Care Practices and Addison County Relocalization Network (ACORN) continued to expand in the number of partners and families served through the Farmacy – Food is Medicine program. This is a 12-week program in which participants receiving a food share with local fresh produce based on referrals from a provider. In 2021, Village Health partnered with ACORN to provide a few shares to their patient population and the offering was expanded to more Porter Primary Care patients referred by the CHT Registered Dietitians. COVID-19 has put additional pressures and constraints on individuals and families to engage and healthy behaviors due to finances, stress, and other challenges. However, this program was able to support those who could financially benefit from receiving fresh produce as well as those with chronic conditions and introducing

healthier options to their diet. Additionally, there was increased funding from the support of Rotary to provide an additional 2 weeks in both October and November to expand the program and produce shared with participants! It was another successful year and we look forward to 2022!

In 2021, the WHI Social Worker at Porter Women's Health started a Mom's Connection group to help new mothers connect with other mothers in the area and share experiences and resources. This stemmed from mothers during prenatal care identifying fear and loneliness of being a new mother. As a result, several mothers have connected over the past year and shared their appreciation for connection and the support of the WHI Social Worker.

CHT had a new class offering in 2021 called "Calming the Anxious Mind. One of our newest CHT Behavioral Health Professional started a skills-based class to provide individuals with various tools, techniques, and peer support to help with daily anxiety. This has been well received and the goal for 2022 is to increase various offerings including anger management and depression.

Key work involved multiple parts of your Blueprint team (PCMHs, Facilitator, CHT) and community partners.

The Five Town Health Alliance FQHC implemented a robust screening for food insecurity and offered gift cards to the local grocery store, a resource packet for Addison County and regular check-ins with the social worker for assistance. Five Town Health Alliance also implemented a giving fridge in which produce was grown by employees in the spring and shared with patients during the summer/fall 2021.

All of the PCMH's engaged in significant work around promoting and offering both the Flu vaccine as well as the COVID-19 vaccine to their patients. This helped remove barriers to patients and allow them to ask questions to their PCP if they had concerns. Additionally, there was an emphasis is establishing care plans for patients in their practices for various concerns.

Quality Improvement Initiatives

In 2021, the CHT lead role shifted to include more PCMH Coordination and efforts. With the reframing of this role, the Porter practices have had increased support for PCMH efforts and were able to do outreach around Diabetes, Adolescence Well Visits, Asthma Action Plans, and Flu/COVID-19 Vaccines. Additionally, the full implementation of EPIC, electronic health record, will allow for the Porter practices to build upon QI work and streamline efforts. The goal is to have a collaborative approve to quality work amongst the affiliates and implement best practices based on priorities.

All of the practices in the Middlebury HSA have maintained their PCMH Status and are working to expand continuous improvement strategies to work toward high quality care and support!

Future Goals

- The UVMHN Porter PCMHs are increasing risk assessment screenings in hopes to identify social determinates of health impacting health and transportation needs. Patient's screening positive for transportation needs are working closely with the case managers who are helping patients get connected to Rides to Wellness and Tri-Valley Transit to get to PCP appointments. Additionally, the goal of this project is to help quantify the transportation need in rural Addison County to support future public transportation projects and funding.
- Goals for 2022 include increasing support for prenatal care with the support of a Screening, Treatment and Access for Mothers and Perinatal Partners (STAMPP) grant. This will provide training for clinicians in various organizations to increase care coordination and mental health support for prenatal and postpartum mothers. This is a collaboration between Counseling Services of Addison County, the PCMH's, MAT team, CHT Behavioral Health Specialist, WHI Social Worker, VHD, and other organizations.
- The Substance Use Treatment and Recovery Committee is made up of spoke providers, service organizations, and MAT staff that focus on coordination of services in the community related to substance use. The goal of the committee is to reduce overdoses and death by suicide by providing services and ensuring individuals are connected within the community. The committee is working on a campaign to increase awareness of overdoses and how to be an involved community member.

- The UVM Health Network is working on strategic plan to increase access to primary care and other health care services. This includes shifting the primary care practices to a reimagined team-based care model that elevates all roles and positions to better provide wrap around services and increase provider access for patients based on care needs.
- In 2021, the Community Health Needs Assessment was completed, and the top three priorities identified included access to health care services, access to mental health services, and housing. This was a community collaborative effort, and the community Health Improvement Plan (CHIP) is being developed for 2022-2025. The CHIP will include areas in which the CHT, MAT, and WHI staff will be involved to reimagine healthcare outside of the healthcare setting, especially to increase access to mental and healthcare services. Additionally, the Self-Management Programs will continue to support chronic-disease management. Addison County is excited to have two trained facilitators for Health Coaches for Hypertension and plan to host a few classes in 2022.

Morrisville Health Service Area

Program Manager: Hannah Ancel

Morrisville by the Numbers

16,026	Blueprint Practices Patient Attribution
8.1	Community Health Team staff full time equivalents (FTEs)
5.0	Spoke staff FTEs
0.5	Women's Health Initiative staff FTEs
11	Self-management workshops held
48	Self-management workshop graduates
3,779	Community Health Team encounters
243	Patients served in area Spokes (Medicaid only)

Morrisville Community Health Team

Morrisville Blueprint Practices Blueprint and ACO Participation

Parent Organization	Practice Site Name	ACO Participation				PCMH	WHI	Spoke
		medicare	medicaid	bcbs	mvp			
Community Health Services of Lamoille Valley	Appleseed Pediatrics		X		X	X		
Community Health Services of Lamoille Valley	Morrisville Family Health Care		X		X	X	X	X
Community Health Services of Lamoille Valley	Stowe Family Practice		X		X	X	X	X
Copley Hospital	The Women's Center						X	
Independent Practice	Family Practice Associates					X		
Independent Practice	Stowe Natural Family Wellness					X		
Independent Practice	Stowe Personalized Medical Care PLLC					X		
Independent Practice	Tamarack Family Medicine		X		X	X		X
Northern Counties Health Care	Hardwick Area Health Center		X	X	X	X	X	X
SaVida	SaVida-Morrisville							X
Treatment Associates	Treatment Associates-Morrisville							X

Community Health Team

In 2021 we continued to work towards building a Community Health Team (CHT) with diverse skill sets to support the care needs in our area. We have 7 spoke offices in out HSA: Our staffing is a combination of staff hired through the administrative entity and pass-through dollars. Family Practice Associates and Hardwick Area Health Center receive pass through dollars to hire their own MAT staff. Currently we have 3 RNs and 1.5 LADCs providing support to the different clinics. The CHT Team follows a similar model. There is a combination of staff hired by the administrative entity and some clinics that receive pass through dollars. Tamarack Family Medicine, Family Practice Associates and Hardwick Area Health Center receive pass through dollars to support their CHT staff. We have a clinician that is hired by Lamoille Health Partners that is located at the Women's Center at Copley as a part of the WHI. Over the last year we have had a few staffing changes and are currently looking to hire an additional LADC for our team.

COVID-19 Response

As the COVID-19 pandemic surged in 2021 our practices implemented new protocols and responses. Partnering with The State of VT Immunization Program, Copley hospital has been providing COVID-19 immunization since the end of 2020. This response has amplified in 2021 and as vaccine became more available. We currently have our FQHC and three of five of our independent practices offering various forms of COVID-19 immunizations (children and/or adult). Rapid COVID-19 and PCR testing has been implemented in 7 out of 8 PCMH practices.

With a grant obtained through The Vermont Program for Quality in Health Care, the local FQHC provided free iPads and Wi-Fi Boosters for patients who were having difficulty in accessing telehealth services. This gave us the ability to provide increased support and care to patients who would not have been able to access care

Accomplishments

The FQHC CHT has accessed federal HRSA funds to help those who have been financially impacted by COVID-19 and do not have other resources. Additionally, they partnered with Capstone Community Action to offer Grocery Cards and Everyone Eats meals to people experiencing food insecurity during this difficult time.

Hardwick Area Health Care Center has established and maintained a Diaper Bank, started a local chapter of the Walk with a Doc program, expanded MAT program, developed a Food Share Veggie Box program for patients in need of food and food-related resources, and in collaboration with Lamoille Health Partners recruited and run the Prevent T2 and Diabetes Management classes. Hardwick Area Healthcare Center also participated in the Suicide Safe Pathways

Grant work. This included staff training (QPR, CALM, CAMS) and collaborative meetings with community partners. They worked with the Designated Agency to improve their current internal protocols for suicide prevention and referrals. They upgraded the suicide screening tool in their EHR to the Columbia Suicide Severity Rating Scale.

We have intensified our focus on addressing Social Determinants of Health as a tool for improving overall health and decreasing healthcare cost across or health service area. The CHT team addresses housing instability, medication affordability, transportation, and food insecurity. Also ensuring that patients with mental health and substance use disorder get connected to resources.

In 2021 Morrisville HSA has seen a significant increase in self-management classes. Currently the HSA has well-attended online diabetes programming with two Diabetes Prevention Programs (DPPs) in maintenance phase, one successfully completed Diabetes Self-Management Program (DSMP) and another scheduled in early 2022. With several newly trained DSMP leaders, our plan is to schedule a minimum of four DSMPs in 2022. We also established a partnership with the St. Johnsbury HSA to promote and offer consistent diabetes prevention and management workshops.

Key work involved multiple parts of the Blueprint team (PCMHs, Facilitator, CHT) and community partners. The Lamoille Health Collaborative (LHC) includes 10 health and human service organizations from across the Lamoille service area. The members are: Lamoille Family Center, Capstone Community Action, Lamoille Home Health and Hospice, North Central Vermont Recovery Center, Lamoille County Mental Health Services, Copley Hospital, Lamoille Restorative Center, Clarina Howard Nichols Center, Vermont Department of Health and Lamoille Health Partners. The LHC meets on a monthly basis. The group works closely to expand access to, integrate, and improve the quality of essential health care services. Currently, the primary population of focus is pregnant women with complex needs. The group has launched several initiatives in addition to responding to the on-going challenges of COVID-19 and its impact on our community. The LHC is also supporting local teams working on Zero Suicide and substance use. The CHT team members work closely with community partners.

Key Quality Improvement work

Despite the unique challenges of 2021 all our primary care providers have maintain their Patient Centered Medical Home status.

Mental Health continued as a high priority of QI engagement in 2021 with 2 offices (Lamoille Health Partners and Stowe Natural Family Wellness) adding and integrating on site mental health staff to increase mental health support and while they aren't BP funded, they augment the team in supporting mental health initiatives.

Our QI facilitator meets regularly with offices to offer support in quality improvement activities as well as to help implement a network of support among all of our offices' quality improvement teams.

Several of our offices are actively trying to recruit staff and providers to expand access to primary care.

Most of our offices have implemented and increased use of alternative appointments through telehealth and will continue to review regulatory changes and CMS rules for further efforts to implement alternative appointments routinely in primary care.

Lamoille Health Partners participated in a Mini-Grant for Suicide Prevention. Funding was used to train staff in Counseling on Access to Lethal Means training. All staff were offered the option for CAMS training as well as Columbia training. An improved workflow was created to assist patients who score high on the PHQ-9 as well as the Columbia Suicide Severity Rating Scale.

The Women's Center has focused and worked diligently towards building strong relationships with community partners through collaboration as well as sharing knowledge and resources. A highlight of this work is one of our midwives presented to our local Children's Integrated Services team regarding pregnancy intention and contraception options.

Future Goals

With the FQHC joining the ACO, we are working towards aligning the quality improvement work for both PCMH and ACO in all our practices. We are striving to build robust quality improvement teams to be embedded in office workflow. We are hoping this will lead to a cohesive and maintained quality improvement effort. The goal is to effortlessly implement QI work as part of everyday practice activities.

All our practices continue to monitor ER usage and hospital admission data and develop strategies for improvement. As this process continues to be resource intensive, we are hoping to explore ways for increase efficiency and improved results.

We continue to promote VITL access for our offices with our goal of improving care coordination and minimize services duplication. EHR and cost limitations constitute the main barrier for expansion on this project.

Several of our offices have been focusing their efforts on well targeted chronic care improvement opportunities. Hardwick Area Health Center continued to engage in diabetes control and has now added hypertension as a key clinical focus through the CDC/VDH 1815 grant-related work. We are hoping to expand this standardized measure to other offices for 2022 quality improvement work.

We will continue to encourage formal staff training to identify and respond to mental health crisis and participation in CAMS-care (Collaborative Assessment and Management of Suicidality) Team.

We are hoping to expand our MAT program for some of our offices and we will continue to collaborate with the Recovery Center on providing offices with access to Harm Reduction packs.

We will aim to build multi-sector collaborative and encourage community conversations and partnerships for a comprehensive, accessible, high-quality local mental health/substance use system.

We will continue to support CHT use in offices and develop a workflow for effective co-visits with providers for Chronic Disease Management.

We have recently partnered with North Central Vermont Recovery Center to offer monthly workshops in person to improve our tobacco cessation programming. Our regional coordinator has joined a local Tobacco Prevention Task Force to connect with local leaders and organizations. We hope that these two new partnerships will help promote and highlight the availability of tobacco cessation workshops in our region.

We will continue our work to implement and increase social determinants of health screenings in our offices.

Newport Health Service Area

Program Manager: Megan Marquissee

Newport by the Numbers

13,957	Blueprint Practices Patient Attribution
5.2	Community Health Team staff full time equivalents (FTEs)
1.9	Spoke staff FTEs
1	Women's Health Initiative staff FTEs
7	Self-management workshops held
21	Self-management workshop graduates
4,445	Community Health Team encounters
123	Patients served in area Spokes (Medicaid only)

Newport Community Health Team

Newport Blueprint Practices Blueprint and ACO Participation

Parent Organization	Practice Site Name	ACO Participation						
		medicare	medicaid	bcbs	mvp	PCMH	WHI	Spoke
North Country Health Systems	North Country Pediatrics		X	X	X	X		
North Country Health Systems	North Country Primary Care Barton Orleans		X	X	X	X		
North Country Health Systems	North Country Primary Care Newport		X	X	X	X		
North Country Health Systems	North Country OB/GYN		X	X	X		X	
Northern Counties Health Care	Island Pond Health Center		X	X	X	X		
SaVida	SaVida-Newport							X

Community Health Team

The Newport CHT is embedded in Primary Care in our Newport, Barton/ Orleans, and North Country Pediatrics locations. We also have Dietician services embedded in the Island Pond Health Center through our community partner at Northern Counties Healthcare.

Having these services embedded in Primary Care has proven highly beneficial to meeting patients' needs and goals. Patients often meet with their providers and CHT members the same day or at the time to allow for partnership and true coordination of care.

COVID-19 Response

Throughout the COVID-19 pandemic, North Country Hospital (NCH) has been a leader in COVID-19 testing, screening, and vaccination in partnership with the State of VT. NCH has been able to quickly adapt to meet our patient's needs by normalizing COVID-19 care in our daily operations at Primary Care. We transitioned to online self-management programs and offering telehealth appointments. COVID-19 had encouraged us to think outside the box and support our patients and community in non-traditional ways like with the use of telehealth. Our CHT has been successfully outreaching with community partners and patients via telehealth to support, educate, and coordinate care. This has been so successful in the right applications, that we envision using this even post COVID-19.

Accomplishments

In 2021 NCH relaunched our WHI program at our North Country Ob/Gyn office, offering a more complex social determinates of health screening and same-day LARC insertion for patients.

Newport HSA was the first HSA in the State to offer Health Coaches for Hypertension, a self-management program designed at Clemson University specifically for participants with high blood pressure. Newport's master trainer trained 23 facilitators that are now leading this program through the State helping reduce the risk of high blood pressure statewide.

In partnership with community partners like Northern Counties Health Care, Umbrella, VDH, Vermont Agency of Human Services and Northeast Kingdom Human Services (just to name a few), Orleans and Northern Essex counties have successfully launched a re-invigorated ACO called Vibrant Community. Tackling large community-based issues as a collective.

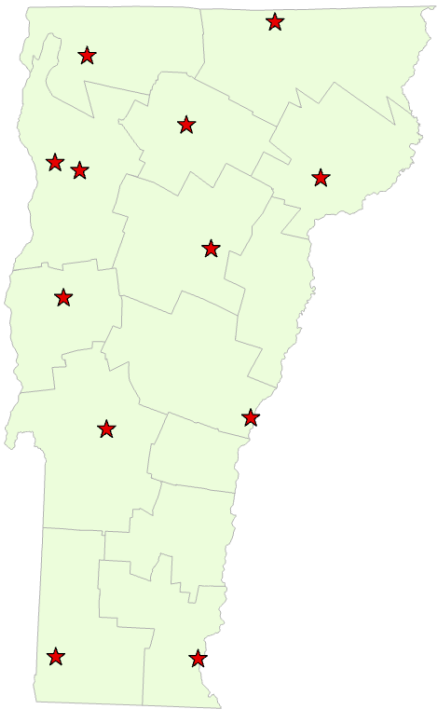
Key Quality Improvement Work

- Provider-level dashboards that address high A1C's, Mammography Screenings, and Td/Tdap Adult Boosters.
- Same Day LARC insertions through our WHI program and OBGYN workflows.
- Implementing a Food Resource Directory for patients screening positive for food insecurities.
- Maintaining a Registered Dietician throughout our Medical Home including our Pediatric office and Island Pond Health Center.

- Embedding a Registered Respiratory Therapist in our Medical home to assist school-aged children with Asthma and Asthma action plans.
- Offering Health Coaches for Hypertension Control class and facilitating statewide class leader training.
- Making EHR workflow enhancements to better report on and track high-risk patient populations.
- Providing proactive outreach for patients with elevated A1C's, Flu shot administration, and patients with Hyperthyroidism.
- Continuing recruitment and enrollment for online self- management programs.
- Offering virtual online Wellness Center programming throughout the year and during the pandemic to promote physical and emotional wellbeing.

Future Goals

- Community Partnerships: Continue building and growing relationships with community partners to help facilitate change with community needs like mental health and substance abuse.
- Chronic Disease Management: Continue to promote and expanse prevention work around chronic diseases like diabetes, and cardiovascular disease.
- Access to Primary Care: Continue with recruitment and retention strategies to build and sustain our workforce. Continue to utilize and expanse Primary Care support services like care coordination.



Planned Parenthood of New England (PPNNE)

Program Manager: Tanya Serota Winston/Kelly Miller

PPNNE by the Numbers

4.8 Women's Health Initiative staff FTEs

4157 Attributed patients statewide (including Rutland PPNNE)

PPNNE Blueprint Practices Blueprint and ACO Participation

Parent Organization	Practice Site Name	ACO Participation				PCMH	WHI	Spoke
		medicare	medicaid	bcbs	mvp			
Planned Parenthood of Northern New England	PPNNE-Rutland						X	
Planned Parenthood of Northern New England	PPNNE - Barre						X	
Planned Parenthood of Northern New England	PPNNE - Bennington						X	
Planned Parenthood of Northern New England	PPNNE - Brattleboro						X	
Planned Parenthood of Northern New England	PPNNE - Burlington						X	
Planned Parenthood of Northern New England	PPNNE - Hyde Park						X	
Planned Parenthood of Northern New England	PPNNE - Middlebury						X	
Planned Parenthood of Northern New England	PPNNE - Newport						X	
Planned Parenthood of Northern New England	PPNNE - St. Albans						X	
Planned Parenthood of Northern New England	PPNNE - St. Johnsbury						X	
Planned Parenthood of Northern New England	PPNNE - White River Junction						X	
Planned Parenthood of Northern New England	PPNNE - Williston						X	

CHT Team

It has been an exciting year at PPNNE with many changes throughout. Most notable is that we are now fully staffed with patient support counselors at each of the 12 health centers in Vermont and a Director of Behavioral Health! We currently have fully embedded patient support counselors (PSCs) in the Barre, White River Junction, Bennington, Brattleboro, Middlebury, St. Johnsbury, Hyde Park, Newport, Saint Albans, Williston, and Burlington centers. There continues to be a patient support counselor located in the Rutland Health Center that is a joint hire between PPNNE and Regional Rutland Medical Center. The new Director of Behavioral Health started in November 2021.

Accomplishments

During the interim, prior to the Director of Behavioral Health onboarding, the IBH (Integrated Behavioral Health) program had wonderful leadership from within PPNNE and achieved many things. With the growing WHI staff the IBH program focused on solidifying referral protocols, workflows and information sharing with medical staff to fully embed WHI staff and embed WHI ethos into care provided. This was a multipronged approach that rolled out over several months. The team began by operationalizing the array of work that is done with patients after screening and referrals made to patient support counselors. The team developed internal referral protocols, a referral tracking system for external referrals, workflow for suicidality, and identified referral network needs for folks who identify as T-LBGQIA and/or BIPOC. Two large trainings were designed and implemented to increase understanding of impact of SDOH on patients and increase evidenced based approaches to supporting patients. The first training focused on de-escalating patients in distress. As the pandemic continues and continues to put an increased burden on many SDOH, the medical staff noticed an increase in patient distress. The training used the lenses of intersectionality, SDOH and the biopsychosocial model to help make sense of patient behavior, provide skills to medical staff to help regulate patients, while reinforcing the importance of screening for SDOH in medical spaces. The second training focused on implementing enhanced screening to a wider net of patients in health centers and provide research and practice space to implement universal use of the CSSRS tool among medical providers. This was a team effort that included many components of PPNNE's health care delivery team: the training team, Clinical Care Directors, the IBH team and the entire health center staff across the 3 states. The training and new workflow around suicidality will provide better care to patients, increased access to patient support counselors as needed, and increased staff confidence in addressing suicidality while working with patients.

Collaboration Within the CHT

It is important to highlight the work that is being done across the state in each county, within each CHT team. The PSC (Patient Support Counselors) at PPNNE have begun working within their local CHT teams. Each PSC is at a different stage of engagement based on length of time in the position. I would like to lift the work of Micah O'Connor, the PSC in Brattleboro and Bennington. He presented to the CHT team in Brattleboro data derived from paper screenings administered during the first two and a half months of WHI embedded practices at the Brattleboro Health center. The larger CHT team is hoping to examine the data collected on SDOH, rates of utilization of PSC services and compare with data obtained from Brattleboro Memorial OBGYN and Four Seasons to better understand how to serve the community without duplicating services.

Continued COVID-19 Response

As we moved into 2021, PSCs moved back into the health centers. Telehealth has proved to be an additional strategy that increases patient access to the PSC. We have found that continuing to offer in person and/or telehealth on an as needed basis helps provide patient access. In regard to safety and COVID-19, every health center follows CDC medical guidelines around risk mitigation strategies and the use of personal protective equipment (PPE).

Key Quality Improvement Work

As PPNNE works towards integrating WHI strategies into each of the health centers, we have begun to create an informal QI process. Feedback was created informally between health center staff, PSC's and the director of Clinical Care and the training team. Out of this informal system came the referral tracking system, improved workflow for screenings, and clear referral process for PSC access. PPNNE has a formal CQI workgroup comprised of multiple departments across the organization. It was an audit completed by this workgroup that initiated the improvement plan around suicidality.

Future Goals

The goal is for continued use of informal and formal CQI practices to inform the work we are doing in the IBH program at PPNNE. As mentioned earlier we have formed informal processes for assessing the work. The informal processes include a regular meeting with the PSCs across the state, and a regular meeting with the PSC's and a

representative from the health care delivery team. We intend to keep those meetings. In addition, PPNNE has an established CQI interdisciplinary workgroup that meets regularly. IBH team representation will join the workgroup to continue to improve services offered and patient outcomes. As always, our goal is to continue to improve and strengthen relationships with community partners and organizations across the state.

Randolph Health Service Area

Program Manager: Patrick Clark

Randolph by the Numbers

10,614	Blueprint Practices Patient Attribution
5.1	Community Health Team staff full time equivalents (FTEs)
1.2	Spoke staff FTEs
0.5	Women's Health Initiative staff FTEs
19	Self-management workshops held
67	Self-management workshop graduates
785	Community Health Team encounters
99	Patients served in area Spokes (Medicaid only)

Randolph Community Health Team

Randolph Blueprint Practices Blueprint and ACO Participation

Parent Organization	Practice Site Name	ACO Participation				PCMH	WHI	Spoke
		medicare	medicaid	bcbs	mvp			
Clara Martin Center	Clara Martin Center							X
Gifford Health Care Inc.	Bethel Health Center		X		X	X		X
Gifford Health Care Inc.	Chelsea Health Center		X		X	X		
Gifford Health Care Inc.	Gifford Health Center at Berlin		X		X	X	X	
Gifford Health Care Inc.	Gifford Behavioral Health and Gifford Addiction Medicine							X
Gifford Health Care Inc.	Gifford Primary Care		X		X	X		X
Gifford Health Care Inc.	Gifford Ob/Gyn and Midwifery		X		X		X	
Gifford Health Care Inc.	Rochester Health Center		X		X	X		X
Independent Practice	South Royalton Health Center		X		X	X		

Community Health Team

Our Randolph Health Service Area (HSA) Community Health Team (CHT) is embedded in each of our primary care practices. Our team consists of both RN's and an LPN's that provide clinical care and care management. We have two care coordinators that are at bachelor's education level. We have mastered level licensed clinicians that support our WHI and MAT programs. We have two Certified Health Coaches as part of our CHT team. Our CHT regularly meets with several local community partners to conduct care coordination for mutual patients. For our ACO-attributed lives, we coordinate care with our ACO Collaborators, and maintain shared care plans in Care Navigator.

COVID-19 Response

Due to COVID-19, we have been hosting our Self-Management Programs virtually instead of in-person. While it is unfortunate that we cannot meet in-person, the virtual platform provides some benefits for participants, and we will likely continue to hold some classes virtually in a post-pandemic environment. Some of our CHT staff members have been assisting with local COVID-19 vaccine clinics and our COVID-19 testing site. Helping with these efforts is extremely rewarding and has actually led to some opportunities to provide CHT services when needs are identified.

Accomplishments

EMS House Calls Project – We have partnered with three local EMS crews to identify high-risk community members who may benefit from recurring non-emergency visits. Gifford Health Care reimburses EMS for these services. EMS completes a 1-page visit summary during each visit, which gets sent to the CHT. The CHT ensures that the summary is uploaded into the patient record and shared with the primary care provider. The CHT follows up with the patient if needs are identified during the EMS visit. We have recurring monthly meetings with the EMS crews to check in on progress with this initiative.

RECC - The Randolph Executive Community Council (RECC) utilizes the Accountable Community for Health framework to bring together integral community stakeholders to organize a coordinated effort towards improved community and individual health with an emphasis on prevention. We address population and public health in our area, through the identification of issues and measures which are most relevant, applicable, and challenging for our community members. Our CHT regularly meets with several local community partners to conduct care coordination for mutual patients. For our ACO-attributed lives, we coordinate care with our ACO Collaborators, and maintain shared care plans in Care Navigator.

RECC Housing Workgroup – This workgroup has worked with the local faith-based community to implement a couple of emergency housing options in the Randolph area. Previously, we had no local emergency housing options.

They are also working with key community partners to increase transitional and permanent housing options in the region.

RECC Nutrition Workgroup – This workgroup organized and hosted the RECC Regional Food Access Summit, which provided a forum for food shelf representatives to come together to network and learn from each other about successful strategies to expand operations and address challenges. We received positive feedback on the event and are exploring ways to further assist our area food shelves moving forward.

Most of our HSA's primary care practices are participating in the CDC 1815 grant work focused on developing and implementing hypertension and diabetes protocols. We also have a quality improvement team participating in the statewide Asthma/COPD Learning Collaborative. All Randolph HSA primary care practices continue to maintain Patient-Centered Medical Home (PCMH) recognition. grant work focused on developing and implementing hypertension and diabetes protocols. We also have a quality improvement team participating in the statewide Asthma/COPD Learning Collaborative. All Randolph HSA primary care practices continue to maintain Patient-Centered Medical Home (PCMH) recognition.

Future Goals

Our Gifford Addiction Medicine department actively participates in Rapid Access to Medication Assisted Treatment in both the Berlin and Randolph areas. We are able to offer appointments to new patients seeking treatment for opioid use disorder within 72 hours of the initial referral. Looking ahead, we are planning to implement the Rethinking Outpatient AUD Detox (ROAD) protocol for people seeking treatment for alcohol use disorder.

In the Randolph area, four individuals trained as facilitators for the new Health Coaches for Hypertension Control program in 2021. We recently began offering this program and are planning to expand these offerings in 2022 so that we can better address heart disease management and control within our community.

Primary care access is an ongoing issue statewide. Our local primary care practices continue to recruit for a number of primary care clinician positions. As a Federally Qualified Health Center, Gifford Health Care is always open to accepting new patients and works closely with patients to try to make that transition as smooth as possible. The Randolph HSA CHT proactively conducts outreach to people seen in the Gifford Emergency Department with no primary care provider and offers assistance in establishing primary care. In addition, we conduct outreach to the ACO Medicaid expanded population to offer primary care and care coordination services.

Rutland Health Service Area

Program Manager: Kathy Boyd

Rutland by the Numbers

30,709	Blueprint Practices Patient Attribution
7.2	Community Health Team staff full time equivalents (FTEs)
8.0	Spoke staff FTEs
3	Women's Health Initiative staff FTEs
2	Self-management workshops held
15	Self-management workshop graduates
7,214	Community Health Team encounters
425	Patients served in area Spokes (Medicaid only)

Rutland Community Health Team

Rutland Blueprint Practices Blueprint and ACO Participation

Bradford Psychiatric Services	Bradford Psychiatric Services-Rutland							X
Community Health Centers of the Rutland Region	Brandon Medical Center	X	X	X	X	X		X
Community Health Centers of the Rutland Region	Castleton Family Medical Center	X	X	X	X	X		
Community Health Centers of the Rutland Region	Mettowee Valley Family Medical Center	X	X	X	X	X		X
Community Health Centers of the Rutland Region	Pediatric Associates	X	X	X	X	X		
Community Health Centers of the Rutland Region	Rutland Community Health Center	X	X	X	X	X		X
Community Health Centers of the Rutland Region	Shorewell Community Health Center	X	X	X	X	X		
Independent Practice	Associates in Primary Care					X		
Independent Practice	Recovery House							X
Independent Practice	DRS PETER AND LISA HOGENKAMP					X		
Independent Practice	Marble Valley HealthWorks					X		
Rutland Regional Medical Center	Rutland HUB							X
Rutland Regional Medical Center	Rutland Women's Healthcare						X	

Community Health Team

The Community Health Team in the Rutland Health Service Area embodies a myriad of models to meet the needs of our patients, practices, and community at large. The Core Community Health Team is comprised of 3 Social Work/Behavioral Health staff along with a RN Case Manager, with 2 of those staff being embedded in the Pediatric Practice of Community Health Centers of the Rutland Region. The Core CHT supports the 4 designated PCMHs by addressing Social Determinants of Health needs through navigation of available supports and services offered locally as well as state-wide. CHT receives referrals to support patients and families with high social and medical complexity that requires more intensive care coordination efforts. This level of staffing allows for outreach to be conducted in a patient-centered approach, through home and community visits in addition to the Primary Care Practice sites.

Additional Community Health Team staffing is supported through pass through funds and is comprised of Panel Management as well as Care Managers embedded within Community Health Centers. These positions support patients to better manage chronic conditions as well as supporting patients in need of Medication Assisted Treatment through RN Care Management and Behavioral Health services.

The Women's Health Initiative is also highly active in the Rutland Health Service Area, supporting Rutland Women's Healthcare as well as the Rutland Planned Parenthood of New England practice site. This CHT initiative provide cares coordination support through an embedded Social Determinant of Health screening model. The success of this effort is due to the multi-disciplinary approach in meeting patient identified needs, while reducing barriers in the navigation and access to community supports and resources.

The Community Health Team has also partnered with the Transitional Care Program (TCP) to provide a more comprehensive approach in support of our patients. While the primary goal of the TCP is to reduce readmission risk following a hospital stay, there are substantial care coordination needs that are key components of this effort. The ability to work seamlessly between the TCP and CHT teams has offered great support to patients not only to decrease the need to rehospitalization, but also enhancing access to Primary Care as well as community services and supports.

COVID-19 Response

CHT and healthcare providers in the Rutland Health Service area continue to work collaboratively on the COVID-19 response efforts for the community. Staffing resources have been limited on all fronts and the healthcare partners have worked together to ensure each Organization has the needed resources to ensure safe and continued care for those effected by the virus. The hospital worked closely with the State to provide vaccinations to the Rutland HSA. Over 50,000 individuals ages 12 and older were vaccinated at the Holiday Inn, this is in addition to the vaccination efforts for all Health Care Providers for the Rutland HSA. The Transitional Care Nurses along with members of the

CHT provided support and guidance to the RCC Education and Engagement Sub-Committee who created the COVID-19 Journal, this team also assisted with the Hospital to Home Model of Care for the COVID-19 population.

An important response to the pandemic is the impact the virus has had on families. The CHT pediatric team has worked tirelessly with the FQHC pediatric providers along with other state and community social service providers to ensure children and families have the support and services needed to persevere during this difficult time.

One area of significant impact has been the increase in mental health needs, in particular the mental health of our pediatric population. Pediatric Emergency Department visits for Suicidal Ideation have increased from 4.02% to 5.87% thus far in 2021 as compared to 2020 - an increase of 42%. In response, Rutland Mental Health has initiated the Child and Family Mobile Response and Stabilization Service. This program provide supports to children under the age of 18, or anyone under the age of 21 if still in high school or voluntary DCF custody. This essential program will assist to reduce the need for emergency level of crisis supportive services.

Accomplishments

Rutland Community Collaborative (RCC) MISSION: Committed to improve the overall health of the Rutland Community through appropriate utilization and access of healthcare services.

The RCC is a "Grassroots" led committee represented by 30 community and State organizations. The Collaborative is comprised of 7 subcommittees, a core team, and overall Stakeholders Meeting. The 7 subcommittees are: Behavioral Health, Clinical Case Review, Transitions of Care, Palliative Care & Hospice, Community Centered Care (Focus High Utilization of Emergency Room Services), Data, and Education & Engagement.

The focus areas for FY21 were Transitions of Care, COVID-19 Response, and Substance and Alcohol Use Disorders and Treatment. The sub-committees focused goals and strategies were developed with these key areas in mind. In addition to the development of a COVID-19 patient journal, the Substance Disorders Journal was created which includes treatment options and supportive care services for friends and families impacted by those effected with substance use disorders. Both journals were developed by the collaborative partners and reviewed by a member of the Patient Family Advisory Council. The journals are being used by all sectors of the Community to ensure our community has the tools required to mitigate the risk of the virus and identify supports for those impacted by SUDs.

Rutland Community Collaborative Executive Committee (RCCEC) Mission: Integration and collaboration to improve health outcomes for the Rutland Region.

The RCCEC follows the Accountable Community for Health (ACH) model. RCCEC updated the vision, mission, and charter during FY21.

The RCC, the RCCEC, and Project Vision have joined forces by creating the "Summit" meeting to prevent duplication of efforts and to ensure goals and strategies are aligned to better meet the social and medical needs of our community. Through the efforts of those at the Summit meeting Project Vision is now hosting the RCC website.

One of the many accomplishments for the Rutland Health Service area was the collaboration between Rutland Regional Medical Center and Community Health Centers of the Rutland Region to streamline data reporting to support the care coordination of needs for established patients attributed to the ACO. The Community Centered Care Committee, which is facilitated by the Community Health Team, fosters collaborative care coordination and communication amongst ACO participating agencies with support from consistent data reporting. The goal is to reduce non-emergent Emergency Department visits, while increasing access to primary care as well as the development of a shared care plan.

Wide-spread community collaboration remains the key component for the success of care coordination efforts in the Rutland Health Service Area. The ability to effectively communicate and efficiently collaborate amongst health care partners and human service agencies alike allows for comprehensive care delivery. Structured opportunities offered by the Rutland Community Collaborative and the Community Health Team facilitated Referral and Care Coordination meeting provides the ability to share organizational updates, educational offerings, and cohesion of service delivery methods.

Quality Improvement Activities

All Rutland Health Service Area Blueprint Practices have Quality Improvement initiatives on-going. The QI Facilitator, Ryan Torres, provide support on these efforts. Some of these initiatives are as follows:

Hogenkamps: Preventive screenings, tobacco screenings, wellness visits, Diabetes preventive screenings, vaccines (including COVID-19), and Advance Directives.

Community Health Centers: Hgb A1C Control, HPV initiation and completion, Adolescent and Adult well visits, Depression screenings for pediatrics, and hypertension monitoring and prevention.

Marble Valley: Diabetes prevention – Hgb A1C, pneumococcal vaccine, Colon Cancer screening, and closing the referral loop process.

Associates in Primary Care: Well visits, Depression screenings for adolescents, tobacco screenings and cessation interventions, efficiency regarding the treatment of Upper Respiratory Infections, and closing the referral loop process.

HUB and SPOKE: QI initiatives focused on reducing waiting times to access treatment through Rapid Access to Medication. Increasing access to MAT treatment by expanding treatment entry points and creating a system where health care professionals prescribe methadone or buprenorphine to patients with opioid use disorders at the time services are requested.

Future Goals

One area of focus for Rutland is the expansion of self-management program offerings. Rutland's self-management program was paused for the greater part of a year, but with the hiring of a full time Regional Coordinator, our Healthier Living Workshop programs will be greatly expanded in the year to come. Efforts are already underway to better engage primary care providers, along with community outreach regarding the varied offerings of self-management programs. Access and use of virtual offerings is another endeavor to enhance. Increasing trained facilitators along with a partnership with Southern Vermont Medical Center to support self-management in the Bennington HSA are additional planned efforts.

Another effort underway is regarding data collection for the Community Health Team. As the Community Health Team supports multiple practices, with separate electronic medical records, the goal is to streamline data collection as a quality improvement initiative. Not only will this effort provide a more comprehensive review of CHT encounters, interventions and outcomes, it will guide the adaptations needed for continuous service delivery improvements.

The use of Shared Care Plans remains an on-going initiative in the Rutland Health Service Area as well. The ability to identify Care Teams, patient directed goals, and overall care coordination efforts amongst health care and community service providers is the key to successful care coordination.

Springfield Health Service Area

Program Manager: Tom Dougherty

Springfield by the Numbers

11,850	Blueprint Practices Patient Attribution
11.2	Community Health Team staff full time equivalents (FTEs)
3	Spoke staff FTEs
0	Women's Health Initiative staff FTEs
34	Self-management workshops held
124	Self-management workshop graduates
1,928	Community Health Team encounters
161	Patients served in area Spokes (Medicaid only)

Springfield Community Health Team

Springfield Blueprint Practices Blueprint and ACO Participation

Parent Organization	Practice Site Name	ACO Participation				PCMH	WHI	Spoke
		medicare	medicaid	bcbs	mvp			
SaVida	SaVida-Springfield							X
Springfield Medical Care Systems	Charlestown Health Center		X	X	X	X	X	
Springfield Medical Care Systems	Ludlow Health Center		X	X	X	X	X	
Springfield Medical Care Systems	Mountain Valley Health Center		X	X	X	X	X	
Springfield Medical Care Systems	Rockingham Health Center		X	X	X	X	X	X
Springfield Medical Care Systems	Springfield Community Health Center		X	X	X	X	X	

Community Health Team

Our Community Health Team, as defined by those staff supported in some part by Blueprint CHT funds, is comprised of a community health worker, BH/SU care coordinator, registered dieticians and diabetes care and education specialists, and staff dedicated to quality improvement and panel management. This team supports all practices in our area either from a central location or by dedicated time at each location, and collaborates closely with our local critical access hospital, Springfield Hospital, and a broad range of community partners. The CHT is a core supplement and support for our clinical care coordinators who are embedded in each primary care practice, the MAT programs, and school-based clinics. Care coordinators assist patients in addressing barriers to care and support individuals' priorities related to their health and wellness and serve as an essential link to navigate and secure services in the community and across the healthcare system.

COVID-19 Response

Adaptability, resilience, creativity and perseverance are all appropriate but inadequate terms to describe how all levels of staff dealt with radical changes that occurred in their personal and professional lives in response to the ongoing COVID-19 pandemic. The CHT and care coordinators quickly became adept at telehealth technology, assisted in a myriad of roles as needed by rapidly changing workflows at primary care practices and energetically reached out to patients facing the additional barriers of restricted access to essential services. Given the unpredictability we must now live with, many of the adaptions developed in response to COVID-19 are expected to remain as options in our daily workflows including telehealth visits, virtual or hybrid meetings, regular COVID-19 testing and remote work as feasible and appropriate. Not only do these practices enable the delivery of critical services, in many instances they enhance accessibility and reduce barriers to care.

Accomplishments

Among the major accomplishments of the past year was of course our continued adaptation to the COVID-19 pandemic in our midst (see above), and the resiliency required as wave followed wave and fatigue and frustrations multiplied both in the community and our teams, the latter being it seemed even more challenged by departures and the difficulty of recruiting in our rural environment. Nevertheless, our practices met the increased demand for behavioral health services with expanded capacity, as did our dental practices. Our behavioral health and primary care practices all participated in the Safer Pathways initiative to reduce deaths by suicide, with all BH staff undergoing CAMS training and all practices having CALM-trained staff on hand. Care coordinators were determined in their outreach to patients who had not been seen during the early phase of the pandemic, resulting in significant rates of re-engagement, and all practices in our HSA achieved PCMH recognition and were cited for advancing quality through health information technology (HIT) by HRSA- all of which was the result of the terrific collaboration between practice QI teams, CHT QI staff and our wonderful QI Practice Facilitator.

Quality Improvement

In addition to the work noted above, our practices and programs made great strides in improving rates of flu vaccination, depression screening, breast cancer screening and controlling high blood pressure and in following up with results of blood tests, x-rays and other tests. In the four QI measures included in DVHAs quality improvement incentive program, the Springfield HSA achieved significant improvements in all four measures, resulting in the highest total improvement score of 10:

- Percent of adolescents with an annual well-care visit: 3 points
- Percent of children up to three years of age who have had a developmental screening: 3 points
- Percent of individuals with hypertension in control: 2 points
- Percent of individuals with diabetes in poor control (HgA1c > 9): 2 points

Future Goals

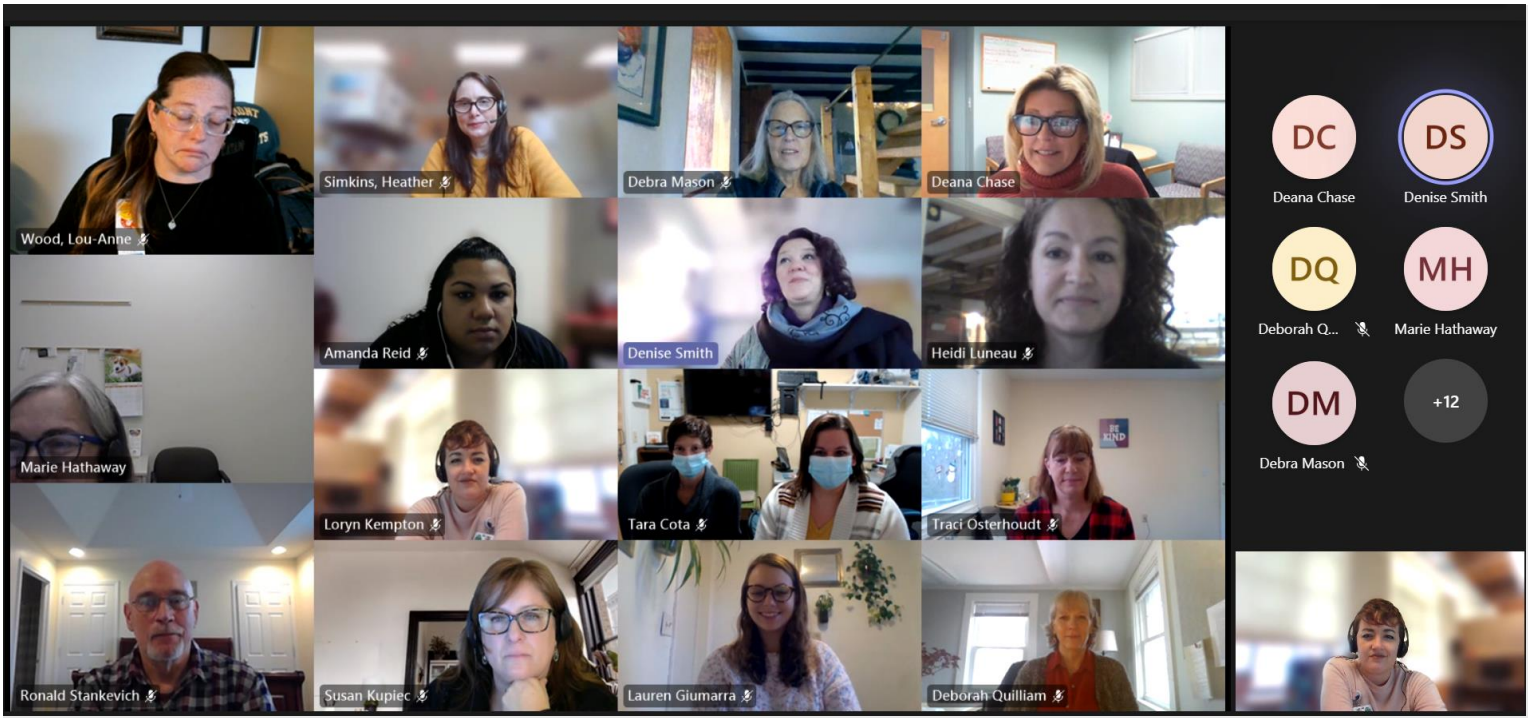
Our practices plan on building on these successes with continued work on these priority measures along with projects to continuously improve patients' experience and access to care. Future goals also include further improvements in the follow-up to positive depression and suicidality screening and working with community partners on strengthening our organizations' capacity to provide trauma-informed care, racial equity and becoming equitable organizations.

St. Albans Health Service Area

Program Manager: Denise Smith

St. Albans by the Numbers

21,301	Blueprint Practices Patient Attribution
10.4	Community Health Team staff full time equivalents (FTEs)
8.3	Spoke staff FTEs
0	Women's Health Initiative staff FTEs
11	Self-management workshops held
7	Self-management workshop graduates
17,312	Community Health Team encounters
369	Patients served in area Spokes (Medicaid only)



St. Albans Community Health Team

St Albans Blueprint Practices Blueprint and ACO Participation

Parent Organization	Practice Site Name	ACO Participation				PCMH	WHI	Spoke
		medicare	medicaid	bcbs	mvp			
BAART	BAART-St. Albans							X
Howard Center	Howard Center-St. Albans							X
Independent Practice	Cold Hollow Family Practice	X	X	X	X	X		X
Northern Tier Center for Health (NOTCH)	Alburg Health Center	X	X	X	X	X		X
Northern Tier Center for Health (NOTCH)	Enosburg Health Center	X	X	X	X	X		X
Northern Tier Center for Health (NOTCH)	Fairfax Health Center	X	X	X	X	X		X
Northern Tier Center for Health (NOTCH)	Richford Health Center	X	X	X	X	X		X
Northern Tier Center for Health (NOTCH)	St. Albans Health Center	X	X	X	X	X		X
Northern Tier Center for Health (NOTCH)	Swanton Health Center	X	X	X	X	X		X
Northwestern Medical Center	NMC - Northwestern Primary Care	X	X	X	X	X		X
Northwestern Medical Center	Northwestern Georgia Health Ctr	X	X	X	X	X		X
Northwestern Medical Center	Northwestern Pediatrics - Enosburg Falls	X	X	X	X	X		
Northwestern Medical Center	Northwestern Pediatrics - Saint Albans	X	X	X	X	X		
Primary Care Health Partners	St Albans Primary Care	X	X	X	X	X		

Community Health Team

The Community Health Team (CHT) in the St. Albans HSA is a vibrant group of RN Care Coordinators (11), MAT professionals (7.5), and Behavioral Health Social Workers (6.5), as well as a community health worker (1) who work directly with patients at the PCMH, specialty practices, and Spoke Practices in our region. We work closely with our designated agency to hire staffing that is embedded in practices. The team is embedded in the practices, and we use a distributed model to approach the comprehensive care of our patients in our region. The team meets bi-monthly to share updates and hear about resources that are available to our community. Our expanded team of participants include long term care facilities, home health, community action, the recovery center, VDH, and the Turning Point.

COVID-19 Response

2021 has been a year of lessons about gratefulness, adaptability, resilience, patience, and continued persistence. As the COVID-19 pandemic continued to surge throughout Vermont and the rest of the world, vaccines were finally approved and distributed in the United States. In the later part of 2020 and the early months of 2021, the community began to take a collective sigh as health care and essential workers were finally able to be vaccinated against the virus. Vermont focused on its most vulnerable and quickly vaccinated seniors in our community. There was an air of celebration as more and more age bands were open, and the vaccine became more available. Many members of the Community Health Team, Blueprint administrative staff, and the State were redeployed for months to support mass vaccination efforts in their communities. Sites were stood up overnight throughout Franklin and Grand Isle Counties to accommodate the demand for vaccine and tremendous community collaboration was required to share vaccine supply, staffing resources, vaccine transportation, and space.

Throughout the winter and early spring, into the beginning of summer, the focus of community health was ensuring the vaccinations were administered and that our community was being inoculated. In June of 2021, we had succeeded in Vermont at being 80% vaccinated leading to the end of the State of Emergency and the mask mandate. Summer was a dream with very few COVID-19 cases and a sense of renewed freedom and success, as we were able to meet again in person, see each other's smiles, and plan for a new future. As the summer turned to fall, however the new Delta Variant emerged, and COVID-19 cases began climbing back

up. Northwestern Medical Center, Vermont Department of Health, and the NOTCH were called upon once again to increase testing and administer booster to adults, as well as begin the pediatric vaccine. Throughout the pandemic the Blueprint Team was part of the COVID-19 response, whether it was coordinating meetings with community partners, including long term care facilities, and home health, or ensuring that health care staff and patients had access to vaccine and testing.

Our adaptability and community coordination has helped to mitigate the COVID-19 pandemic in our region. Continuing to be adaptable and continuing to coordinate services will help us throughout other challenges and not just during a pandemic.

Accomplishments

In addition, as this pandemic has persisted, it has demonstrated how fragile the state of our mental health is. Having embedded behavioral health team members in our primary care practices has proven to be an incredible benefit. NCSS, our designated agency for mental health, reported a 12% increase in individuals seeking mental health for the first time in our primary care practices (177 of them were pediatric patients). Telemedicine has become a very useful tool for both primary care visits and counseling and has created a unique opportunity to provide care to our community.

Increases in substance use disorder are impacting communities nationally and locally. Franklin and Grand Isle counties are not immune to the pervasiveness of this disease. This year has been once again filled with multiple changes and opportunities. Our MAT team has remained relatively stable and is working more intentionally together as a team. The Howard Center, our Designated Agency for substance use disorder, is expanding spoke services, harm reduction, and drop-in hours. Rapid Access to Medication (RAM) has been implemented in our Emergency Department and our partnerships with our community partners continue to grow, as we add Recovery Coaches from the Turning Point to our Emergency Department and work with the Howard Center to continue our Screening, Brief Intervention, and Referral to Treatment (SBIRT) program.

Community connections have been another key theme for 2021. Key work involved multiple parts of our Blueprint team (PCMHs, Facilitator, CHT) and community partners. Community groups have continued to meet, and others are shifting to focus on new goals. The CHT for the St. Albans Health Service Area has maintained bi-monthly meetings throughout the year and has been instrumental in having a consistent place to share information, knowledge, and connect throughout the pandemic. Our region's Unified Community Collaborative and Regional Clinical Performance Council have held on throughout the pandemic and plan are underway for a continued learning collaborative. Most recently there have been discussions about how to work more intentionally on creating a vibrant and effective Accountable Community for Health structure in our region, and there is ongoing work being done to at our committee level to explore options. In the past year the Community Housing Resource Team (CHRT), the FGI Community Partnership, the Prevention Network, and our Hunger Council have all maintained regular meetings and work continues to move forward despite the challenges posed by the pandemic

Quality Improvement

- Zero Suicide grants at NCSS and Cold Hollow Family Practice
- Continued work at NMC OBGYN for Women's Health Initiative Workflow
- Support family practices with PCMH annual recognition
- Expanded QI workforce at NMC and NOTCH

Future Goals

The Blueprint for health team is continuing to support care team participation and shared care planning, by participating in the RCPC Transitions of Care Committee and working with NMC and our community to implement best practices around patient transitions. We are exploring our internal and external processes and any gaps. Our team is engaged in the process and working through some of the challenges.

We are working with the ACO to understand the new 2022 tri-annual reporting structure or care coordination, including the quality metrics.

Our current learning collaborative is reforming to include broader population health learnings focused on community prevention to include more community partners to support broad movement on reducing deaths by overdose/suicide.

Will continue to work with VDH and the Blueprint on chronic disease management self-management programs and promote them to primary care providers and other community partners.

St. Johnsbury Health Service Area

Program Manager: Katie Bocchino

St. Johnsbury by the Numbers

13,792	Blueprint Practices Patient Attribution
17.8	Community Health Team staff full time equivalents (FTEs)
2	Spoke staff FTEs
0.75	Women's Health Initiative staff FTEs
5	Self-management workshops held
36	Self-management workshop graduates
11,935	Community Health Team encounters
121	Patients served in area Spokes (Medicaid only)

St. Johnsbury Community Health Team

St Johnsbury Blueprint Practices Blueprint and ACO Participation

Parent Organization	Practice Site Name	ACO Participation						
		medicare	medicaid	bcbs	mvp	PCMH	WHI	Spoke
BAART	BAART-St. Johnsbury							X
Northeastern Vermont Regional Hospital	Corner Medical		X	X	X	X		
Northeastern Vermont Regional Hospital	Kingdom Internal Medicine		X	X	X	X		
Northeastern Vermont Regional Hospital	St. Johnsbury Pediatrics		X	X	X	X		
Northeastern Vermont Regional Hospital	Women's Wellness Center		X	X	X		X	
Northern Counties Health Care	Concord Health Center		X	X	X	X		
Northern Counties Health Care	Danville Health Center		X	X	X	X	X	
Northern Counties Health Care	St. Johnsbury Family Health Center		X	X	X	X	X	

Community Health Team

The six Behavioral Health Specialists (BHS), including a BHS Supervisor; six RN Care Coordinators; seven Community Health Workers (CHW) and Community Resource Coordinators, including a CHW Lead; Social Worker; four Mental Health/ Substance Abuse Clinicians; and two Spoke RNs are all members of the Community Health Team (CHT) involved in care coordination in the St. J HSA. The CHT staff are embedded in the practices throughout the region. Additionally, at Community Connections, individuals can access help from Community Health Workers finding and connecting to primary care and social and community services without having to make an appointment (before COVID-19, Community Connections was walk-in). The CHT meets monthly to share resources with partner agencies throughout the region. The St J HSA holds two other monthly meetings during which partner agencies throughout the region attend and discuss the Team Based Care approach and to identify solutions and system-level changes to gaps and barriers in care.

COVID-19

NCHC and NVRH have been leaders in COVID-19 testing and vaccination in partnership with the State of VT through mobile vaccine clinics and a stand-up clinic in a vacant space at the Green Mountain Mall. NCHC and NVRH have successfully incorporated COVID-19 -care into regular primary care, including negative pressure rooms, enhanced infection control procedures and offering telehealth appointments. NCHC also offers COVID-19 testing and vaccination through primary care, and NVRH has implemented and maintains a drive-thru COVID-19 testing and vaccination operations center and process for patients and also opened a Respiratory Care Clinic. The St. Johnsbury HSA was the first in the state to offer Monoclonal Antibody COVID-19 infusions for COVID-19 -positive patients.

Accomplishments and Quality Improvement work

NCHC actively participates in several community health partnerships, including organizing and running a six-week Rise & Walk Program with six local Providers with support from RiseVT which attracted 18 individuals, and the Pop-Ups in the Park series in collaboration with the Physically Healthy Collaborative Action Network of NEK Prosper! Pop-Ups in the Park featured 18 classes led by seven different fitness professionals and was attended by 85 participants. Seventy five percent of participants surveyed reported their physical activity level increased as a result of attending and 86% reported their mental health benefitted from attending.

In partnership with NVRH, NCHC launched the Northern Express Care Walk-in Primary Care location in downtown St. Johnsbury in November 2020. Utilization has been steadily growing throughout the year, patient satisfaction is high and there has been a reduction in avoidable ER visits as a result.

NCHC and NVRH practice St. Johnsbury Pediatrics participated in the Suicide Safe Pathways Grant work which has included staff training (QPR, CALM, CAMS) and collaborative meetings with community partners, including the Designated Agency, to improve protocols for suicide prevention and individualized care navigation.

NCHC has upgraded the suicide screening tool in their EHR to the Columbia Suicide Severity Rating Scale.

St J Pediatrics developed an internal workflow to address suicidality, incorporating the Columbia Suicide Severity Rating Scale into practice, and also collaborated with the Designated Agency to develop an external workflow.

Building off the work that was done with St. Johnsbury Pediatrics as part of the grant, NVRH is working implementing SBIRT and Y-SBIRT into the Emergency Department's workflow, in collaboration with St. Johnsbury Pediatrics where Y-SBIRT is already implemented. This work also includes training Emergency Department nurses and Care Managers in Youth Mental Health First Aid and/or CAMS.

NVRH also began working to develop a referral workflow and communication feedback loop and to strengthen coordination of care between the NVRH adult practices and the Designated Agency when Emergency Services has been called, and to improve internal documentation and workflow for Emergency Services.

NCHC and NVRH are focused on diabetes and hypertension as a key clinical focus through the CDC/VDH 1815 grant-related work. Three years into the Diabetes work, patients are making beneficial lifestyle changes, losing weight and building a support system. Providers have more tools to support patients to prevent and manage diabetes, and it is making a real difference.

NCHC developed diabetes protocols and added them to clinical guidelines; established Continuous Glucose Monitoring pilot; implemented a Food Bundle Bag program for patients with Diabetes or Prediabetes; expanded Diabetes Passport Program with DHMC endocrinology; continued recruitment and enrollment for weekly Diabetes Support Group, Prevent Type 2 Diabetes classes and 1:1 coaching sessions with Certified Diabetes Care and Education Specialist; provided Hypertension Diagnosis and Treatment Goals education for Providers; updated hypertension clinical guidelines; established blood pressure cuff lending program; offered new Health Coaches for Hypertension Control class; and made EHR template enhancements to record home blood pressure measurements.

NVRH's adult practices have collaborated with the NVRH Hospital Outpatient Diabetes Clinic to create a shared workflow around Continuous Glucose Monitoring and Team Based Care Management of Diabetes. The Community Health Workers developed a workflow for how they will support patients and the Medical Practices with management of Diabetes for patients who are experiencing challenges or barriers. The practices developed and finalized a Hypertension Management protocol and are working on a Heart Disease Prevention Protocol. They've also begun working on a project of identifying patients with pre-diabetes and implementing outreach to them with education materials. They've discussed building diabetes education into the EMR to print automatically upon discharge.

NVRH practice St. Johnsbury Pediatrics implemented a new vision screening process for strabismus detection in children between ages 1 – 6. Within the first year of implementation, which included developing a screening workflow, integrating the EMR and outreaching to patients, 18% of eligible children were screened.

The St. J HSA has led an introductory Basics of Team Based Care training for several years. This year, NVRH developed two additional Team Based Care trainings: Team Based Care: Community Partner Engagement and Communication, which expands on the ideas and workflows introduced in the basic training; and Team Based Care: Leadership Training for people in supervisory or leadership positions, which familiarizes supervisors with important Team Based Care concepts and terminology. As of the end of September 2021, 142 staff from about 20 partner organizations have been trained in Team Based Care.

Future Goals

The St. Johnsbury HSA will continue building on our success around prevention and management of diabetes and hypertension/cardiovascular disease as reported above including deep community work and interventions to address the root causes of poor health. We will continue training staff to identify and respond to those in mental health crisis

and participation in the NEK CAMS-care (Collaborative Assessment and Management of Suicidality) Team, expanding the MAT program, and furthering multi-sector collaborative and community conversations and partnerships around building a comprehensive, accessible, high-quality local mental health/substance use system of care in the Northeast Kingdom. We will continue always ensuring individuals in the Emergency Department, Express Care, or who are discharged from Inpatient are supported in navigationn to primary care, while also focusing on aggressive recruitment and retention strategies to build and sustain our workforce. We'll also continue making improvements to patients' telehealth experience, expand the Express Care walk-in primary care model, and hire and train more Community Resource Coordinators/Community Health Workers to help maintain our already strong community and healthcare partnerships and referral workflows to ensure expedited care, whether it be for social determinants or physical healthcare needs.

Windsor Health Service Area

Program Manager: Jill Lord

Windsor by the Numbers

12,292	Blueprint Practices Patient Attribution
7.4	Community Health Team staff full time equivalents (FTEs)
3.0	Spoke staff FTEs
0	Women's Health Initiative staff FTEs
17	Self-management workshops held
124	Self-management workshop graduates
22,080	Community Health Team encounters
246	Patients served in area Spokes (Medicaid only)

Windsor Community Health Team

Windsor Blueprint Practices Blueprint and ACO Participation

Parent Organization	Practice Site Name	ACO Participation						
		medicare	medicaid	bcbs	mvp	PCMH	WHI	Spoke
Bradford Psychiatric Services	Bradford Psychiatric Services-White River Junction							X
Independent Practice	Upper Valley Pediatrics; PLLC		X	X	X	X		
Independent Practice	White River Family Practice	X	X	X	X	X		
Independent Practice	Connecticut Valley Recovery Services							X
Little Rivers Health Care	Little Rivers - Bradford					X		X
Little Rivers Health Care	Little Rivers - East Corinth					X		X
Little Rivers Health Care	Little Rivers - Wells River					X		X
Mt. Ascutney Hospital and Health Center	Mt. Ascutney Hospital Physician Practice	X	X	X		X		
Mt. Ascutney Hospital and Health Center	Ottauquechee Health Center	X	X	X		X		

Community Health Team

There are three amazing Community Health Teams in the Windsor HSA. The Upper Valley Community Health Team in the Bradford area consists of Community Health Workers serving the clinics of Little Rivers Health Care and an LPN serving Upper Valley Pediatrics. The team, hired by Little Rivers Health Care, is decentralized and embedded in the various practice sites throughout the area. The part-time LPN is embedded in Upper Valley Pediatrics. White River Family Practice hired a wonderful and experienced RN, who is embedded in the practice and provides outreach to community partners. Mt. Ascutney Hospital and Health Center employs two social workers and two RNs and a Community Health Worker (grant supported). Each of the above professionals display high-quality clinical expertise and compassionate caring in their service. Each of the teams adopts the care coordination role bringing together community partners for joint care planning and care conferencing with lead care coordinators. Each team provides access to the resources and referrals needed by the patients they serve. Each team meets with community partners on a regular basis (MAHHC meets weekly. Other teams meet monthly) to collaborate, jointly problem solve and share resources. Each team addresses clinical care, social and emotional care, behavioral health and social determinants of health.

COVID-19 Response

Each of the health teams became educated experts to link the people they serve to the existing COVID-19 resources and provide the education needed to prevent, reduce harm and treat chronic disease in the midst of the pandemic. Virtual collaboration and care coordination has made it easier for the team members to maintain safety, overcome time constraints of travel and geography in a rural state. This is an improvement that will continue post pandemic. This virtual methodology has also transformed our self-management workshops. We have been able to overcome transportation barriers and risk for COVID-19 by adopting a virtual platform. This too will continue.

- We are able to understand in real-time the availability of home services so that expectations can be shared with patients.
- Volunteers in Action has been critical in helping with needs for food, transportation, and prescription pickup.
- Taxi service and Rides to Wellness have helped with transportation during the critical time.
- The Family Place Parent-Child Center went virtual to continue their services.
- Our Blueprint Team went virtual and has become stronger and more accessible to each other over the pandemic.

- Assisted living has provided higher levels of care during the time when people could not be admitted to long-term care beds.
- Our Community Health Worker started a support group to decrease social isolation for elders.
- Our Wellness Coach started at a mental health wellness clinic as a bridge for patients while they are waiting to be admitted to mental health treatment programs.
- SASH, HASS, MAHHC, Ever North, Senior Solutions and Stewart Properties worked together to transform Windsor Village from a place that only had Wi-Fi in the administrative office to cover the entire building. Free computers and tech-support were offered in the process.
- VeggieVanGo served approximately 330 families each month.
- Everyone Eats in both Windsor and Woodstock were wonderful support for individuals and families.
- The food shelves provided phenomenal support to families and became more integrated partners in our care coordination efforts.

Accomplishments

Regional coordination improvements for connecting patients to VDH Healthier Living Workshops

- Virtual group meetings have improved participation and access.
- VDH recognized the online linkage to www.myhealthyvt.org [myhealthyvt.org] on www.littlerivers.org [littlerivers.org] was notably used by individuals to connect to HLWs. An easily navigated link to help patients and care coordinators connect to virtual classes.

Upper Valley Community Collaboration

- Completed a 2021 Community Health Needs Assessment and identified the following items as the top priorities for the group
  - Transportation
  - Reliable and safe housing
  - Understanding access to resources
- Taking action in the community
  - Sasha joined the CoC as a UVUCC representative
  - Ashleen joined Bradford Housing as a UVUCC representative
  - New UVUCC member Marylyn Cook was hired as the Bradford Housing Counselor to assist people who require housing assistance.
- Dashboard of milestones
  - 1,000s of pounds of fresh produce
  - 100s of frozen meals
  - Incredible care coordination and volunteer collaboration in order to provide food services to patients.

Upper Valley Pediatrics

Able to hire a part-time LPN for care coordination who was oriented by the Little Rivers Health Care Coordinators and become part of the Upper Valley Care Coordination Team.

White River Family Practice

- Screening for depression
- Working creatively to get our patients connected with mental health resources/psych.
- Currently actively participating in 2 collaboratives – 1 for pediatrics & 1 for adults.

Mt. Ascutney Hospital and Health Center

Accomplishments include the Community Health Implementation Plan (CHIP) which organizes multi sector networks to address the issues of strengthening families, senior health, alcohol and substance misuse, food security, housing and spiritual health for Collective Impact in the face of a devastating pandemic. We work with 99+ community partners implementing Best Practice Strategies as an Accountable Community for Health. Each of the above-mentioned networks have delineated Problem Statements, completed Root Cause Analysis, established aims, adopted and are implementing Best Practice Strategies as well as outlining Results Based Accountability metrics. Link to annual report here.

Accomplishments

- Having more community partners come to our weekly care coordination meeting, making connections and helping each other with care coordination and resource sharing.
- Helping provide increased resources and referrals for ED patients.
- The team has become well known and respected drawing more people and into this work.
- We have streamlined care coordination so that key people can collaborate and connect with the right person.
- The team makes it easy for new professionals to make connections.

Quality Improvement Activities

Key work for each of the teams included achieving all standards as a Patient Centered Medical Home. Each of the practices continue to be recognized by NCQA within the annual recognition process.

The Community Health Teams are the stars. They provide panel management, care coordination, outreach, referral and integration with community partners on behalf of the individuals and patient populations we serve. These teams work with all ages of individuals and groups providing care in the continuum of prevention through high risk complex chronic care management. They concentrate their care, education and expertise in the arenas of clinical care encompassing both physical and mental health and the Social Determinants of Health. Two of the major emphasis of our key work relates to the prevention of opioid fatalities and addressing homelessness within the context of a critical housing shortage

Key QI work concentrates on the prevention and management of chronic disease, mental health and addressing the barriers to health. As such concentrated efforts have been made to implement best practices in the management of diabetes and hypertension. Testing and Immunizations for COVID-19 and flu have taken a central stage. Promoting maximal achievement for all immunizations has been a challenge in an environment of anti-vac. sentiment. We have a team working with the Vermont Department of Health that is working to overcome these barriers. Key work includes reducing ED and inpatient admissions, reducing deaths by overdose and suicide and improving access to care. Other quality improvements in 2021 include:

- Improved communication and care coordination among community partners.
- Developing systems and resources to help people experiencing homelessness including access to tents, camping supplies and other materials, the development of a Housing Resource Guide, the development of a Homeless Resource Guide and a 211 outreach poster for those experiencing homelessness.
- Developing trusting relationships among team members to better provide care coordination for patients.
- Sharing information for such things as workshops and human services.
- Sharing information for such things as bed availability and staffing availability.
- Building strong Health Center and school district care coordination systems

Future Goals

MT Ascutney Hospital and Health Center will continue to accept the responsibility as a backbone organization within our HSA as an Accountable Community for Health addressing our most vexing problems to reach our vision and become a resilient community that is physically well, mentally well, well housed, well fed, financially secure, socially connected and valued. This takes trust, shared goals and resources with all partners. We completed our 2021 Community Health Needs Assessment this month and are anxious to move forward to address priorities together. We accept the gravity of addressing chronic disease management, mental illness, reducing death by overdose/suicide and assisting patients to have access to needed care as a strong network of community partners. This includes primary and specialty care demands, the ability to not only adopt best practices within agencies, but also to integrate those agencies in a way that maximizes impact. This is where we shine!

- Continue to build trusting relationships and improved communication and care coordination among team members.
- Reinstitute the fourth trimester mother's group.
- Strengthen the mental health wellness clinic via building a structured relationship between MAHHC and HCRS to provide a facilitated bridge to therapeutic services.
- Analyze the 2021 Community Health Needs Assessment, create and implement a Community Health Implementation Plan.

We treasure the opportunity to work with the Blueprint for Health as trusted partners in improving the health and well-being of our communities!

Conclusion

The Blueprint for Health has a long and respected history of nimbly responding to local communities with its strong support of primary care and seamless coordination with community-based organizations to meet the physical health, mental health, and social service needs of Vermonters. This local, responsive, and unwavering commitment proved to be invaluable during the onset of the 2020 COVID-19 pandemic and continued to enable providers to meet the changing care needs of all Vermonters in the 'new normal' of 2021. Blueprint central and regionally based team members, employed by many different organizations yet all moving in the same direction, work in collaboration to improve our system of care efficiently and compassionately, one person-to-person interaction at a time.