

Term	Abbreviation	Definition
Accountable Care Organization ¹	ACO	A group of healthcare providers and hospitals who collaborate to provide high-quality, coordinated care to a defined group of patients, with the ability to share in any cost-savings achieved.
Administrative Entity ²	AE	The primary financing and management entity for Blueprint Community Health Teams and Blueprint field staff within each health service area.
Administrative Services Only ³	ASO	A type of self-funded health insurance plan where an employer takes full responsibility for the medical claims made by its employees but contracts an outside organization or third-party administrator to provide specific administrative services, such as claims processing and enrollment. Sometimes these plans are referred to as “self-funded” or “employer-funded” plans.
All-Payer Model ⁴	APM	An alternative payment model being piloted in the state of Vermont between January 1, 2017 and December 31, 2025 with support from the CMS Innovation Center; a statewide system of ACO participation in which healthcare quality and value are incentivized consistently by the majority of payers (Medicare, Medicaid, and commercial insurers) for the majority of providers with the goal of promoting ongoing health system transformation and improved population health.
Care Coordination ⁵	--	Intentional organization of patient care activities and deliberate information sharing among care team members aimed at providing safe, effective, and person-centered health care for patients and their families; often encompassing a wide range of specific activities including assessment of patient needs, support for patient goals, assistance with transitions of care, linkage to community resources, ongoing patient follow-up, and high-quality communication.
Community Health Teams ^{2,6}	CHT	Multidisciplinary teams that collaborate with primary care clinicians to provide evidence-based interventions aimed at promoting whole person health; may include registered nurses, care coordinators, social workers, health educators, registered dietitians, community health workers, and master’s level trained behavioral health clinicians; may range from embedded services co-located within a single clinic to centralized services shared across multiple clinics within a region.
Community Health Worker ⁷⁻⁹	CHW	A frontline public health worker who has a significant understanding of the community they serve (usually with shared

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Designated Mental Health Agencies ¹⁰	DA	ethnicity, language skills, or life-experiences) and who functions as a liaison to bridge the gaps between the community and social services, facilitate access to high-quality culturally-competent healthcare, and decrease health disparities; may perform a variety of specific activities including community education, care coordination, health coaching, outreach and advocacy, and social support; associated with improved chronic disease management and mental health outcomes as well as significant cost-savings.
Developmental Understanding and Legal Counsel for Everyone ¹¹	DULCE	DULCE is an approach based in the pediatric care setting that proactively addresses the social determinants of health, promotes the healthy development of infants, and provides support to their parents, during the first six months of life. DULCE introduces a Family Specialist trained in child development, relational practice, and problem-solving into the pediatric care team. Family Specialists attend well-child visits with families and providers.
Employee Retirement Income Security Act of 1974 ¹²	ERISA	A federal law establishing minimum standards for the majority of employer-sponsored retirement and health insurance plans, excluding those that are maintained by government agencies or churches. Qualifying ERISA plans are exempt from many state regulations or requirements.
Fully-Insured Plan ^{13,14}	--	A health plan in which the insurance company assumes the financial responsibility for medical claims.
Healthcare Effectiveness Data and Information Set ¹⁵	HEDIS	A collection of standardized and validated quality measures established by the National Committee for Quality Assurance (NCQA) and widely reported by Medicare, Medicaid, and commercial insurers; consisting of more than 90 measures across the following domains: (1) effectiveness of care, (2) access/availability of care, (3) experience of care, (4) utilization and risk adjusted utilization, (5) health plan descriptive information, and (6) measures reported using electronic clinical data systems; designed to allow for comparisons between health plans and against various regional benchmarks.

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Health Service Area ²	HSA	A Blueprint for Health geographic region, based roughly on Vermont Department of Health hospital service areas (version HSA4), which is used for Blueprint program administration and payment purposes.
Hub & Spoke Model ¹⁶⁻¹⁸	--	A novel approach to the provision of evidence-based, medication assisted treatment for opioid use disorder based on the bidirectional movement of patients between regional opioid treatment program (OTP) specialty addiction centers (Hubs) and community clinics with integrated office-based opioid treatment (OBOT) programs supported by nursing and licensed mental health staff (Spokes); first developed in Vermont in 2013 and subsequently adopted/adapted by multiple states nationwide; associated with significant increases in timely access to treatment for opioid use disorder in the State of Vermont. Wraparound support services are currently Medicaid-funded only, but available to all.
Medication for Opioid Use Disorder ¹⁹	MOUD	The current gold standard for the treatment of opioid use disorder; generally consisting of buprenorphine, methadone, or naltrexone administered in combination with harm reduction strategies; highly effective and associated with increased patient survival, improvements in treatment retention, increased employment, and decreased criminal activity. Also known as Medication-Assisted Treatment (MAT) for opioid use disorder.
National Committee for Quality Assurance ²⁰	NCQA	An independent non-profit organization founded in 1990 with the goal of improving healthcare quality; known for developing the Healthcare Effectiveness Data and Information Set (HEDIS) as well as for the establishment of rigorous programs for health plan accreditation and patient-centered medical home recognition; contracted by a number of federal, state, and private agencies to assist with healthcare innovation, evaluation, and improvement. NCQA sets standards and recognition criteria for Blueprint Patient-Centered Medical Homes (PCMHs).
Panel Management ²¹	--	An approach to healthcare delivery in which a care team monitors the health needs of an assigned list of patients and proactively engages them in activities to optimize wellness (rather than relying on them to present for clinical visits and request appropriate care).
Patient-Centered Medical Home ^{22,23}	PCMH	A model of primary care delivery that seeks to provide accessible, comprehensive, whole-person-centered care in a coordinated and team-based fashion; typically allows for the provision of preventive care, acute and chronic disease management, and mental health care within a single setting;

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		certified in accordance with standards published by the National Committee for Quality Assurance (NCQA); and associated with improved clinical outcomes, increased patient engagement in follow-up and treatment, and decreased utilization of the emergency department in many studies. Patients who receive their primary care services at Blueprint Patient-Centered Medical Homes are often referred to as the Blueprint Attributed Patient Population or PCMH Primary Care Attributed Population.
Patient Panel ²¹	--	A list of patients assigned a provider or care team who is then responsible for delivering preventative healthcare as well as acute and chronic disease management.
Peer Support Workers ^{24,25}	PSW	Individuals with lived experience who are trained to support others in recovery from mental health or substance use disorders; generally characterized by a more informal and less hierarchical dynamic than that of the traditional health care team; associated with improved outcomes including increased hopefulness and decreased healthcare utilization among patients in recovery.
Per Member Per Month (Blueprint) ²	PMPM	A capitated payment model in which practices receive a standardized monthly payment from an insurer to cover a defined monthly set of services provided to their patients (in contrast to a fee-for-service model, in which insurance payment is variable depending on the specific services provided); for population based payments, this is calculated by multiplying the attributed patient population of a provider for a specific insurer by a predetermined rate. Also known as a Per Patient Per Month (PPPM) rate.
Population Health ²⁶	--	The health status and outcomes of a group of individuals, often identified according to geography, age, sex, ethnicity, occupation, or other specific factors.
Pregnancy Intention Initiative ²⁷	PII	A Blueprint program providing dedicated training, funding, and staff to participating PCMH and OB/GYN practices supporting enhanced psychosocial screening, comprehensive family planning counseling, and timely access to long-acting reversible contraception (LARC) among individuals ages 15-44 years of age who can become pregnant; formerly referred to as the Women's Health Initiative and renamed in 2023 to be more inclusive of transgender, nonbinary, and genderfluid identities. Currently only Medicaid funded, but available to all patients.
Pregnancy Risk Assessment Monitoring System ²⁸	PRAMS	Vermont PRAMS is an ongoing survey of Vermont mothers who have recently given birth. PRAMS is a project of the Centers for Disease Control and Prevention (CDC) and the Vermont

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Quality Improvement Model ^{29,30}	QI	<p>Department of Health. The goal of PRAMS is to improve the health of mothers and infants by reducing adverse outcomes such as low birth weight, infant morbidity and mortality, and maternal morbidity.</p>
Resource Use Index Score ³¹	RUI	<p>This measure is based on software developed by HealthPartners as part of their Total Cost of Care (TCOC) measurement system, which has been endorsed by the National Quality Forum (NQF). This methodology applies nationally accepted weighting methods such as Medicare Severity Diagnosis Related Groups (MS-DRGs) for inpatient services, Current Procedural Terminology codes (CPTs) and associated ambulatory Payment Classifications (APCs) for outpatient facility services, and CPTs and associated Resource-Based Relative Value Scale (RBRVS) relative weights for professional services to measure the relative intensity of services. Each patient-centered medical home (PCMH) in the Blueprint program receives an RUI score relative to the state average, which is indexed at 1. The lower the RUI score the better a practice ranks for their attributed adult and pediatric members.</p>
Self-Funded Insurance Plan	--	<p>A health insurance plan in which the employer or plan sponsor assumes direct financial responsibility for the insureds' medical claims. Typically, these are created by an employer for their employees, and often they are administered by one of the larger insurance companies.</p>
Self-Management Programs ^{32,33}	--	<p>Evidence-based educational programming (such as the National Diabetes Prevention Program) aimed at helping individuals with chronic conditions better manage their own health and improve wellness; with programming supported by the Vermont</p>

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		<p>Blueprint for Health, managed by the Vermont Department of Health, and found at the following website: https://www.myhealthyvt.org/.</p>
Social Determinants of Health ^{34,35}	SDOH	<p>The larger social conditions that affect a person’s health including, but not limited to: housing, transportation, education, economic opportunity, employment, air and water quality, access to healthy food, access to green space, violence, and racism/discrimination; often identified as key contributors to disparities between populations. Sometimes also referred to as social drivers of health or Health Related Social Needs (HRSN).</p>
Support and Services at Home ³⁶	SASH	<p>A voluntary statewide program providing services to support health and wellness among Vermont Medicare beneficiaries who live independently at home and in senior housing; staffed by local program coordinators and nurses who collaborate with participants on the creation of individualized healthy living plans, host optional wellness check-ins, and partner with community organizations to develop social, educational, and exercise programming; associated with increased engagement in primary care, decreased Emergency Department utilization, and improvements in blood pressure and diabetes management among program participants.</p>
Third-Party Administrator ³⁷	TPA	<p>A company contracted by a health insurance provider to perform administrative duties such as claims processing, billing, and enrollment.</p>
Vermont Chronic Care Initiative ³⁸	VCI	<p>A program that provides short-term case management services to Vermont Medicaid enrollees with complex health and resource needs; ultimately intended to link participants to local patient centered medical homes, care coordination services, self-management programming, and resource supports.</p>

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