VERMONT Blueprint for Health

BLUEPRINT 101: GLOSSARY OF KEY TERMS

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 dieticians, 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 an intimate understanding of the community they serve (usually with shared

Term	Abbreviation	Definition
		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.
Designated Mental Health Agencies[10]	DA	Private, non-profit agencies that partner with the Vermont Department of Mental Health to provide mental health services, program delivery, and outcomes monitoring within a designated region of the state; for example: Health Care & Rehabilitation Services (HCRS) in Windsor and Windham Counties; Howard Center in Chittenden County; and Rutland Mental Health Services in Rutland County.
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 formedical 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.

Term	Abbreviation	Definition
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;

Term	Abbreviation	Definition
		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

Term	Abbreviation	Definition
		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.
Quality Improvement Model[29,30]	QI	A systematic approach emphasizing continuous efforts to reduce variation and improve the quality of healthcare delivery using a variety of approaches and tools, including the Model for Improvement (MFI), workflow mapping, assessments, audit and feedback, benchmarking, and best practices research. The most common approach, Plan Do Study Act (PDSA) cycle involves: ● P = Plan → understand the local environment; develop a team, set project aims, and identify key interventions to meet these aims ● D = Do → implement the proposed intervention on a small scale; collect data to measure improvement ● S = Study → analyze and display data; identify key lessons learned ● A = Act → use lessons learned to determine best next steps, including further adjustment of an intervention or adoption on a larger scale
Resource Use Index Score[31]	RUI	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.
Self-Funded Insurance Plan	--	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.
Self-Management Programs[32,33]	--	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

Term	Abbreviation	Definition
		Blueprint for Health, managed by the Vermont Department of Health, and found at the following website: https://www.myhealthyvt.org/
Social Determinants of Health[34,35]	SDOH	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)**.
Support and Services at Home[36]	SASH	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.
Third-Party Administrator[37]	TPA	A company contracted by a health insurance provider to perform administrative duties such as claims processing, billing, and enrollment.
Vermont Chronic Care Initiative[38]	VCI	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.

References:

1. Accountable Care Organizations (ACOs): General Information. Centers for Medicare and Medicaid Services. https://innovation.cms.gov/innovation-models/aco
2. Vermont Blueprint for Health Manual. Department of Vermont Health Access, Blueprint for Health; 2025. https://blueprintforhealth.vermont.gov/document/blueprint-manual-2025
3. Banton C. Administrative Services Only (ASO): Definition, Pros & Cons. Investopedia. Published June 1, 2023. https://www.investopedia.com/terms/a/administrative-services-only.asp
4. Vermont All-payer ACO model. Centers for Medicare & Medicaid Services. https://www.cms.gov/priorities/innovation/innovation-models/vermont-all-payer-aco-model
5. Care coordination. Agency for Healthcare Research and Quality. https://www.ahrq.gov/ncepcr/care/coordination.html
6. Blueprint Community Health Teams. Vermont Blueprint for Health. https://blueprintforhealth.vermont.gov/about-blueprint/blueprint-community-health-teams
7. Community Health Workers. Vermont Department of Health. Published February 20, 2024. https://www.healthvermont.gov/systems/health-professionals/community-health-workers
8. Community Health Worker (CHW) Toolkit. Centers for Disease Control and Prevention. Published August 31, 2023. https://archive.cdc.gov/www_cdc_gov/dhdsp/pubs/toolkits/chw-toolkit.htm
9. Kangovi S, Mitra N, Grande D, Long JA, Asch DA. Evidence-based community health worker program addresses unmet social needs and generates positive return on investment: A return on investment analysis of a randomized controlled trial of a standardized community health worker program that addresses unmet social needs for disadvantaged individuals. *Health Aff (Millwood)*. 2020;39(2):207-213. doi:10.1377/hlthaff.2019.00981
10. Designated and Special Services Agencies. Vermont Department of Mental Health. https://mentalhealth.vermont.gov/individuals-and-families/designated-and-special-services-agencies
11. DULCE https://csap.org/our-work/project/dulce/
12. ERISA. U.S. Department of Labor. https://www.dol.gov/general/topic/health-plans/erisa
13. *2022 Employer Health Benefits Survey*. Kaiser Family Foundation; 2022. https://www.kff.org/report-section/ehbs-2022-section-10-plan-funding/
13. Fully Insured Plans vs. Self Insured Plans. Business Benefits Group. Published April 13, 2018. https://www.bbgbroker.com/fully-insured-plans-vs-self-insured-plans/
14. HEDIS. National Committee for Quality Assurance. https://www.ncqa.org/hedis/
15. Hub and Spoke. Vermont Blueprint for Health. https://blueprintforhealth.vermont.gov/about-blueprint/hub-and-spoke
16. Brooklyn JR, Sigmon SC. Vermont Hub-and-Spoke Model of Care for Opioid Use Disorder: Development, Implementation, and Impact. *Journal of addiction medicine*. Jul/Aug 2017;11(4):286-292. doi:10.1097/ADM.0000000000000310
17. Rawson R, Cousins SJ, McCann M, Pearce R, Van Donsel A. Assessment of medication for opioid use disorder as delivered within the Vermont hub and spoke system. *J Subst Abuse Treat*. 2019;97:84-90. doi:10.1016/j.jsat.2018.11.003
18. Substance Use Disorder Treatment Options. Substance Abuse and Mental Health Services Administration (SAMHSA). Published April 11, 2024. https://www.samhsa.gov/substance-use/treatment/options
19. About NCQA. National Committee for Quality Assurance. https://www.ncqa.org/about-ncqa/
20. Knox L, Brach C. Module 31: Facilitating Panel Management. In: *AHRQ Publication No. 150060-EF: Primary Care Practice Facilitation Curriculum*. Agency for Healthcare Research and Quality; 2015. https://www.ahrq.gov/sites/default/files/wysiwyg/ncepcr/tools/PCMH/pcpf-module-31-facilitating-panel-management.pdf
21. van den Berk-Clark C, Doucette E, Rottnek F, et al. Do Patient-Centered Medical Homes Improve Health Behaviors, Outcomes, and Experiences of Low-Income Patients? A Systematic Review and Meta-Analysis. *Health Serv Res*. 2018;53(3):1777-1798. doi:10.1111/1475-6773.12737

22. Patient Centered Medical Home (PCMH). National Committee for Quality Assurance. https://www.ncqa.org/programs/health-care-providers-practices/patient-centered-medical-home-pcmh/
23. Peer Services. Vermont Department of Mental Health. https://mentalhealth.vermont.gov/services/peer-services
24. Workforce: Peer Support Workers. National Alliance on Mental Illness. https://www.nami.org/advocacy/policy-priorities/improving-health/workforce-peer-support-workers/
25. Kindig D, Stoddart G. What is population health? *Am J Public Health*. 2003;93(3):380-383. doi:10.2105/ajph.93.3.380
26. Pregnancy Intention Initiative (Formerly Known as "Women's Health Initiative"). Vermont Blueprint for Health. https://blueprintforhealth.vermont.gov/about-blueprint/womens-health-initiative
27. Pregnancy Risk Assessment Monitoring System. Vermont Department of Health. https://www.healthvermont.gov/stats/population-health-surveys-data/pregnancy-risk-assessment-monitoring-system-prams
28. Quality Improvement. Johns Hopkins Medicine Center for Nursing Inquiry. Published March 2022. https://www.hopkinsmedicine.org/nursing/center-nursing-inquiry/nursing-inquiry/quality-improvement
29. Edgman-Levitan S, Shaller D, Campione J, Zema C, Abraham JR, Yount N. *The CAHPS Ambulatory Care Improvement Guide: Practical Strategies for Improving Patient Experience*. (Rybowski L, ed.). Agency for Healthcare Research and Quality (AHRQ); 2017. https://www.ahrq.gov/sites/default/files/wysiwyg/cahps/quality-improvement/improvement-guide/cahps-ambulatory-care-guide-full.pdf
30. Blueprint Performance Payment Calculation Methodology. Vermont Blueprint for Health https://blueprintforhealth.vermont.gov/document/blueprint-performance-payment-calculation-methodology-180103pdf
31. Self-Management Programs. Vermont Blueprint for Health. https://blueprintforhealth.vermont.gov/about-blueprint/self-management-programs
32. What Is Self-Management Education? Centers for Disease Control and Prevention. Published July 17, 2018. https://archive.cdc.gov/www_cdc_gov/learnmorefeelbetter/sme/index.htm
33. Social Determinants of Health. Healthy People 2030. https://odphp.health.gov/healthypeople/priority-areas/social-determinants-health
34. Social Determinants of Health at CDC. Centers for Disease Control and Prevention. Published May 15, 2024. https://www.cdc.gov/public-health-gateway/php/about/social-determinants-of-health.html
35. Learn About SASH. Support and Services at Home. https://sashvt.org/learn-about-sash
36. Kagan J. Third-Party Administrator (TPA): Definition and Types. Investopedia. Published September 17. 2023. https://www.investopedia.com/terms/t/third-party-claims-administrator.asp
37. Vermont Chronic Care Initiative. Agency of Human Services, Department of Vermont Health Access. https://dvha.vermont.gov/providers/vermont-chronic-care-initiative