REPORT TO THE VERMONT LEGISLATURE

Agency of Human Services

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Annual Report on Blueprint for Health

In accordance with Act 18 V.S.A. § 709

Submitted to: House Committee on Health Care
Senate Committee on Health and Welfare
Health Care Oversight Committee

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The Agency of Human Services strives to improve the health and well-being of Vermonters today and tomorrow and to protect those among us who are unable to protect themselves.

VERMONT Blueprint for Health

VERMONT

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I. EXECUTIVE SUMMARY

Legislation and 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 Blueprint for Health was established to promote high-quality care that integrates advanced primary care, specialty care and community-based services to impact Vermonters' health and wellbeing. Advanced primary care encompasses prevention services as well as integration of care and services for people with complex health and social needs. Supported by multi-payer participation, the Blueprint has built a foundation of advanced 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 and in the community. 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 & Spoke System of Care for individuals with opioid use disorder and specifically supports primary care practices providing medication for opioid use disorder. The Blueprint also created the Women's Health Initiative (renamed Pregnancy Intention Initiative), to ensure access to services that support pregnancy intention. In 2023, the Blueprint program was further expanded to include a CHT Expansion Pilot Program to address mental health, substance use disorder, and social determinants of health within primary care.

Program Evolution

Act 78 of 2023 provided two years of funding for several pilot projects targeted at the expansion of health services related to mental health and substance use in Vermont, including expansions of the Blueprint for Health's CHTs and the Health Department's Hub opioid use treatment centers and Developmental Understanding and Legal Collaboration for Everyone Family Specialist program. In close coordination with the Secretary, Department of Health, Department of Mental Health, Department of Vermont Health Access, and Director of Health Care Reform, the Blueprint staff convened workgroups and scheduled stakeholder meetings to develop the CHT Expansion Pilot. The result was a substantial increase in payments to CHTs so that Health Service Area Administrative Entities could expand vital services to address the mental health and substance use needs of the population in an integrated way. As of November 15, 2024, a total of 119 practices (representing 93% of PCMHs in Vermont) attested to participate in Year 2 of the Pilot, and a total of 56.76 full-time equivalent (FTE) staff positions have been hired using Pilot funding, including 34 FTE community health workers (CHW) and 17 FTE team members working in mental health or substance use patient care.

Patient-Centered Medical Homes

The PCMH is a model of care that has transformed how primary care is organized and delivered in Vermont. There are currently 128 participating primary care practices in this initiative. Of these practices,

126 have sustained National Committee of Quality Assurance (NCQA) PCMH recognition[1] from previous years, and two practices underwent full transformations. Participation of practices in the PCMH program has remained relatively stable over the last five years, with small amounts of attrition occurring annually due to retirements or consolidations, and small increases due to newly opened practices or acquisitions.

Community Health Teams

Along with the PCMH model, CHTs are integral to the success of the Blueprint. These teams, funded by commercial and public payers, provide services to patients that are not generally covered by insurance. Services can include care coordination, social work, brief mental health interventions, referrals to services, and numerous other interventions free of charge and without regard to insurance status. Currently, there are a total of 201 staff (124.35 full-time equivalent staff) working as members of the CHTs across the state. These positions include nurses, social workers, mental health counselors, health educators, registered dietitians, community health workers, panel managers, and others who work to provide whole-person care for Vermonters. Notably, the number of active full-time equivalent Community Health Workers on CHTs has increased from 7.6 before the expansion to 41.7 as of November 2024. Similarly, the number of active full-time equivalent CHT staff providing mental health or SUD patient care increased from 8.3 prior to the Expansion Pilot to 25.4 as of November 2024.

The Blueprint tracks the number of patients served by CHT staff, including their insurance type where possible. This information indicates that CHTs serve individuals with a variety of insurance types, highlighting the importance of the Blueprint's universal approach. In 2024, practices continued to improve the capacity to track patients, encounters, and payers without compromising patient confidentiality.

[1]The National Committee on Quality Assurance (NCQA) sets standards around the following elements of the PCMH model: 1) team-based care; 2) understanding and managing patient needs; 3) patient-centered access and continuity; 4) care management protocols; 5) care coordination and transition protocols; and 6) continual performance measurement and quality improvement. https://www.ncqa.org/wp-content/uploads/2019/06/06142019_WhitePaper_Milliman_BusinessCasePCMH.pdf

Hub & Spoke

Hub & Spoke is Vermont's system of medication for opioid use disorder (MOUD) support for people in recovery from opioid use disorder. The Blueprint administers the Spoke part of the Hub & Spoke system while the Department of Health administers the Hubs. Vermont continues to demonstrate substantial access to medication-assisted treatment for Vermonters with opioid use disorder by providing nurses and mental health clinicians as a team to offer evidence-based treatment and provide Health Home services for Vermonters with opioid use disorder.

Pregnancy Intention Initiative

The Pregnancy Intention Initiative (PII) strives to support women and other people who can become pregnant in their efforts to experience healthy pregnancies, avoid unintended pregnancies, and build thriving families. The PII provides increased mental health staffing at specialty practices and utilizes the existing CHT at Blueprint PCMH practices. If a patient identifies as needing support, they have access to a mental health clinician for brief interventions, counseling, and navigation to community-based services and treatment as needed.

Self-Management Programming

The Blueprint and the Vermont Department of Health maintain a Memorandum of Understanding to work closely together for the provision of Self-Management Programming through My Healthy Vermont workshops. While the Blueprint still provides the funding and oversight of the programming, the Health Promotion and Disease Prevention (HPDP) unit within the Department of Health administers the programs through grants to local hospitals and Federally Qualified Health Centers (FQHC). This partnership takes advantage of the additional funding and content expertise that exists within HPDP through the My Healthy Vermont program, and pairs it with Blueprint's influence at the local level. During 2024, the Blueprint worked with the Department of Health in the evolution of the "regional coordinator" model to one prioritizing local staff with specialized statewide roles, called "engagement specialists." This change aims to improve efficiency and effectiveness in the administration of the programs, enrollment of participants, and connections with primary care and specialist practices.

From October 2023 through September 2024, the Department of Health and the Blueprint offered 71 workshops, with a total of 293 individuals completing a program. The Diabetes Prevention Program had the largest number of workshop completers.

Evaluation

The Blueprint annually reports patients' experience of care as required by Vermont statute. Since 2011, this task has been fulfilled through the administration of the Consumer Assessment of Healthcare Providers Survey (CAHPS) for Clinicians and Groups with PCMH questions included. The results of this survey [PDF] provide the broadest statewide look at patient experience of primary care in Vermont. The results are also used to support PCMH recognition by NCQA; and, most recently, as part of the quality reporting under payer contracts with OneCare Vermont under the All-Payer Accountable Care Organization Model.

Health Service Areas (HSAs)

The Blueprint staff in each HSA are responsible for the continued success of the program and have worked during 2024 to address the ongoing needs of their communities. Section V of this report includes in-depth information provided by each HSA, such as details about CHT staffing and structure, community health priorities and special projects, and other details that describe the important work of the Blueprint field teams.

II. 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, CHT Leaders, and Quality Improvement (QI) Facilitators. This network has been integral to facilitating local transformations and increasing collaboration across community partners.[2]

Building on the PCMH and CHT model, the Blueprint program has expanded to include the Hub & Spoke System of Care for individuals with opioid use disorder and specifically supports primary care and specialty practices providing medication for opioid use disorder. The Blueprint also created the Women's Health Initiative, renamed the Pregnancy Intention Initiative (PII), to ensure access to services that support pregnancy intention. In 2023, the Blueprint program was further expanded to include a CHT Expansion Pilot Program to address mental health, substance use disorder, and social determinants of health within primary care.

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. This report describes the activities and progress of the Blueprint during 2024.

[2]Community Partners 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.

A. Executive Committee

The Blueprint for Health statute defines the membership and role of the Blueprint Executive Committee as an advisory body for the Executive Director. At the time of publication, there is one vacancy on the Blueprint Executive Committee. The committee met six times in 2024, providing guidance and input for all Blueprint proposals and analyses. The minutes and materials for each meeting can be found on the Blueprint website.

B. Program Evolution: Community Health Team Expansion Pilot

Act 78 of 2023 provided two years of funding for a pilot project targeted at enhancing health services related to mental health and substance use in Vermont through expansion of the Blueprint for Health's CHTs, including Developmental Understanding and Legal Collaboration for Everyone (DULCE) family specialist program. Act 78 also expanded funding for the Health Department's Hub opioid use treatment centers.

In coordination with the Secretary, Department of Health, Department of Mental Health, Department of Vermont Health Access and Director of Health Care Reform, the Blueprint staff developed the CHT Expansion Pilot in 2023. The Pilot, now in its second year, makes payments to CHTs so that Health Service Area Administrative Entities can expand vital services to address the mental health and substance use needs of the population in an integrated way. Expanded CHTs include additional staff serving as Community Health Workers, Mental Health and Substance Use Counselors, and Social Workers, and an addition of Family Specialists to serve in pediatric or family medicine primary care practices with the DULCE model.

1. Community Health Team Expansion

The Blueprint created three implementation workgroups—Program Design, Measurement and Evaluation, and Payment—consisting of key stakeholders throughout the state. These workgroups met virtually during the winter and spring of 2024 to monitor the overall direction and focus of the Pilot as it entered its second year. Information about the

Blueprint CHT Expansion Pilot can be found here, including slides, presentations, workgroup materials, and meeting minutes.

Practices were required to submit an attestation form to indicate their participation in the second year of the CHT Expansion Pilot. As of November 15, 2024, a total of 119 practices (representing 93% of PCMHs in Vermont) attested to participate in Year 2 of the Pilot.

Community Health Team positions filled using CHT Expansion funding are tracked centrally. As of November 15, 2024, a total of 56.76 full-time equivalent (FTE) staff positions have been hired using Pilot funding, including 34 FTE community health workers and 17 FTE team members working in mental health or substance use patient care. All Health Service Areas have hired staff, giving the Pilot statewide reach.

All practices participating in the CHT Expansion Pilot engaged in a second round of chart reviews to follow the development of screening patterns, how patients are identified for CHT services, CHT interventions provided, and CHT support for navigation to services during the Pilot. Detailed results of the chart review will be available in the first quarter of 2025.

The Blueprint for Health is increasing the number of supports available to practices for implementation, training, quality improvement, and evaluation. Contracts have been executed for Specialized QI Facilitators and training providers. The central office surveyed the field on training needs and facilitated one work group to discuss findings from the survey. The Blueprint-contracted with the Center for Health and Learning and trainings began on the following topics: motivational interviewing, structural competency, the role of community health workers and supervisors, and trainings by the Pride Center of Vermont on LGBTQIA+ issues. The central office also engages with Agency of Human Services teams to support team-based care in each Health Service Area with community partners to support patients with complex medical and social needs.

2. Developmental Understanding and Legal Collaboration for Everyone

Vermont's Developmental Understanding and Legal Collaboration for Everyone (DULCE) program is overseen by the Vermont Department of Health (VDH) Division of Family and Child Health with the approach's required Continuous Quality Improvement led by the Vermont Child Health Improvement Program (VCHIP) at the University of Vermont. VDH and Blueprint work collaboratively to achieve DULCE implementation through the CHTs, including partnering on sustainability and expansion planning for DULCE Family Specialists to serve the needs of infants 0–6 months as well as the needs of children up to age 5 in pediatric practices. Funding for Family Specialists is delivered to the relevant Administrative Entity, with the Blueprint Program Manager working closely with the local Parent Child Center to hire and support the Family Specialist in the HSA.

The Blueprint has created a Memorandum of Understanding with VDH to support Family and Child Health in building a pediatric model that will take components of the DULCE approach and extend this beneficial work beyond six months of age to provide universal screening, referrals, and supports to practices that serve families with children ages 0-17. Family child health began trainings in September 2024 on topics such as Vermont Developmental Surveillance, Screening and Referral, and Promoting Healthy Families, Infants and Children.

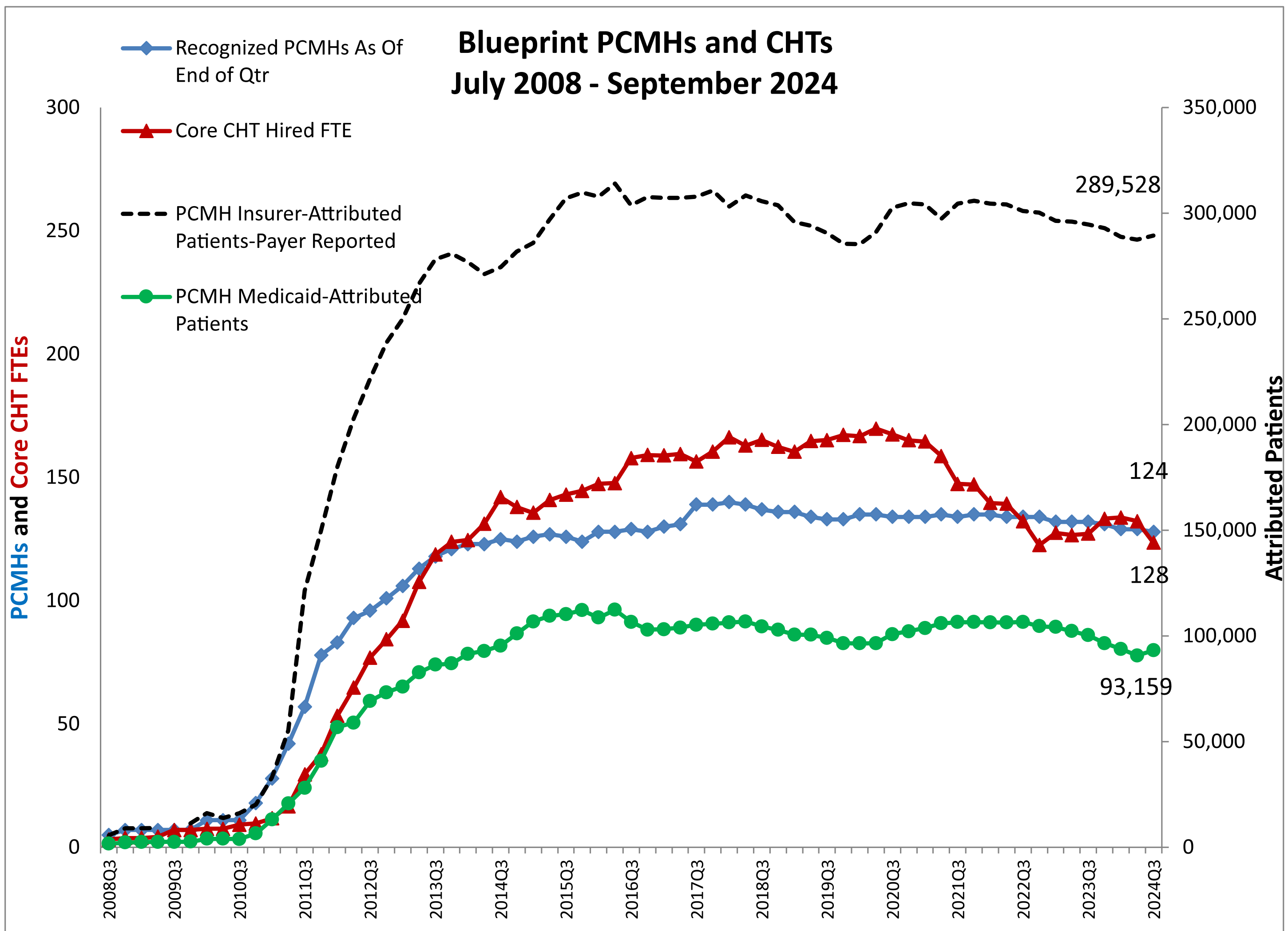
3. Community Health Team Expansion Pilot Evaluation

Two contracts for external evaluation of the CHT Expansion Pilot have been signed. A qualitative evaluation by Market Decisions Research is underway. The qualitative evaluation will include interviews and focus groups with patients, families and caregivers, providers, CHT staff, and administrative entity staff, as well as surveys for all the above groups to gather information on their experiences with the Pilot.

A quantitative evaluation conducted by MedicaSoft is also underway. The quantitative evaluation will focus on insights available from claims data. Results are anticipated in late 2025 or early 2026, depending on release dates of claims data from insurers.

III. PROGRAMMATIC UPDATES

A. Patient-Centered Medical Homes



The Patient-Centered Medical Home (PCMH) is a model of care that has transformed how primary care is organized and delivered in Vermont. Vermont selected the National Committee for Quality Assurance (NCQA) PCMH recognition model in 2008, which is now the most widely adopted PCMH evaluation program in the country.

In 2024, practices that were recognized PCMHs provided evidence and/or attestation that they:

- clearly define practice leadership organization, care team responsibilities, and protocols for how the practice partners with patients, families, and caregivers;
- meet standards for data collection, medication reconciliation, evidence-based clinical decision support, and other activities;
- follow care management protocols to identify patients who need more closely managed care;
- maintain systems and protocols for information sharing and management of patient referrals between primary care and specialty care practices; and
- implement processes and practices for performance measurement, goal setting, and ongoing participation in quality improvement activities.

For 2024, NCQA provided some additional guidance for annual reporting rate thresholds, signaling that practices should be performing at a certain level for core Patient-Centered Medical Home Standards. Annual requirements for care plans were also enhanced, which strengthened the requirement of patient involvement in the care planning process and tries to ensure that the care plan is a tool that is meaningful and accessible to patients/families/caregivers (i.e. uses plain language, avoids codes and jargon). Finally, effective 2024, practices were required to report on standardized measures in the Quality Improvement concept from a list of approved measures published by NCQA.

One practice completed a new transformation into a PCMH in 2024. Another practice that had previously been a recognized PCMH and was impacted by the 2024 requirement that all PCMHs must use an EMR was acquired by another organization and underwent a comprehensive transformation. Four recognized practices did not renew their PCMH recognition in 2024 due to retirement, consolidation, or uncertainty about continuation of practice at that site.

One hundred twenty-six (126) practices sustained recognition as a PCMH in 2024 by attesting that they meet the core requirements and providing additional evidence required for annual reporting. Typically, these practices began active preparation work six to nine months ahead of their anniversary date, working on ensuring that they understood any new standard requirements, were sufficiently able to provide the required evidence for standards that must be reported on an annual basis (e.g. medication reconciliation rates), and selected and worked on a minimum of six quality improvement projects across the domains of clinical quality measures, resource stewardship measures, appointment availability, and patient experience of care.

Practices may be randomly selected for audit by NCQA and may be required to provide evidence and reports related to the core standards that they attest to on an annual basis. Approximately 5% of Vermont PCMH practices were audited by NCQA in 2022 and 2023.

Seven practices were randomly selected for an in-depth NCQA audit in 2024.

This evolution of the recognition process has allowed for a greater focus on continuous quality improvement work in the practice while continuing to raise the quality standard of care in PCMHs. Practices are currently preparing to meet new standard requirements for 2025.

With more than a decade of support for primary care through the PCMH initiative, Vermont is well poised to embrace novel federal models focused on primary care quality and investment.

B. Quality Improvement Facilitation

The Blueprint currently offers participating practices the services of a Quality Improvement (QI) Facilitator. QI facilitators support practices by focusing on implementation of evidence-based care or models of care to improve patient outcomes and experiences. QI Facilitators are highly skilled in quality planning (using data, feedback from patients, community members, employees, and other key stakeholders to guide strategy) and continuous quality improvement (applying the science of improvement to achieve desired aims and address performance).

Presently, there are thirteen QI Facilitators (11.8 FTE) assigned to work with Blueprint-participating practices in a geographic area, and one specialized QI Facilitator working across the State. General QI Facilitators are considered local experts in the PCMH Model and coach practices to achieve and retain NCQA recognition. These facilitators work on an ongoing basis to support continuous quality improvement activities within their practices and regions and assist with quality improvement efforts related to panel management and outreach, care coordination, promotion of individual health and wellness, chronic condition management, patient experience of care, and ongoing value-based care transformation in alignment with state-led health care reform priorities.

For the Community Health Team Expansion Pilot, QI facilitators worked diligently with practices to assist with setting goals and creating implementation plans for screening all populations for developmental milestones, mental health needs, substance use concerns, and health related social needs. QI Facilitators completed training with the Care Transformation Collaborative of Rhode Island to expand their knowledge and skills to support the integration of mental

health, substance use, and social determinants of health interventions in PCMHs. Facilitators also supported organizations and primary care teams in developing their skills and processes to integrate new mental health providers and community health worker services into their practice environments. QI facilitators engaged with practices to complete screening analysis spreadsheets and CHT chart reviews.

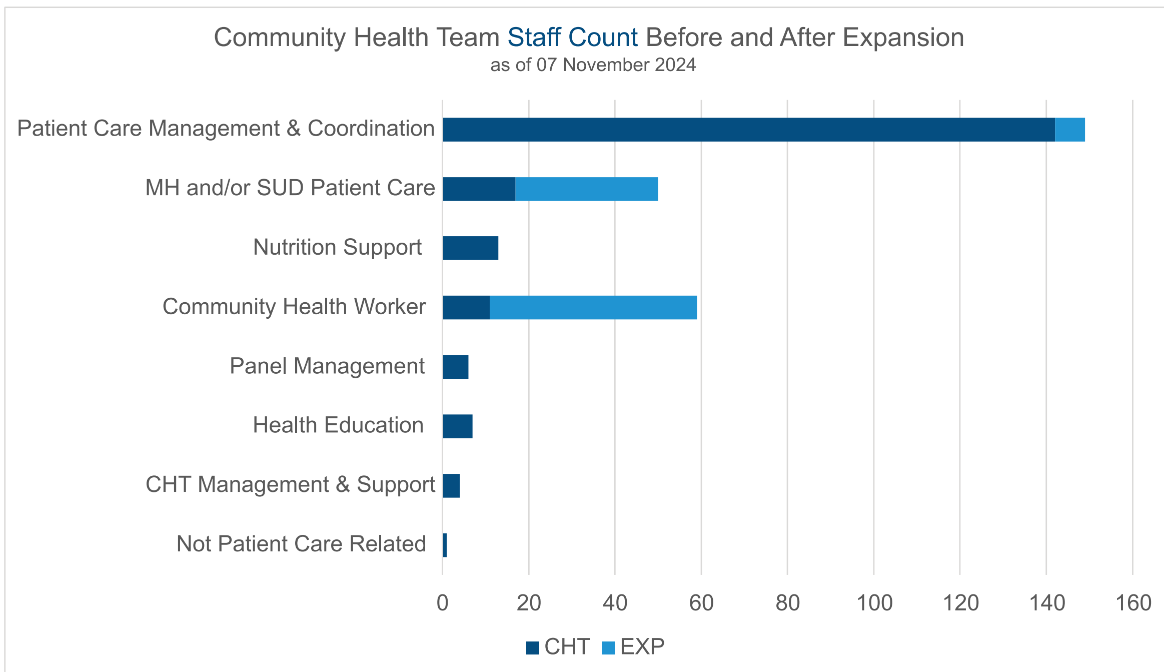
The specialized QI facilitator completed a literature review on complementary and alternative medical (CAM) approaches to depression, anxiety and substance use disorders. This review of available evidence for CAM treatment approaches for depression, anxiety and anxiety disorders, and substance use disorders, reviewing lifestyle changes, nutrition and nutraceuticals, various psychological interventions, acupuncture, and other therapeutics formed the basis for an academic detailing offering on the same topic, aiming to enhance provider and clinician knowledge on CAM therapies and provide strategic insight for integration into clinical practice.

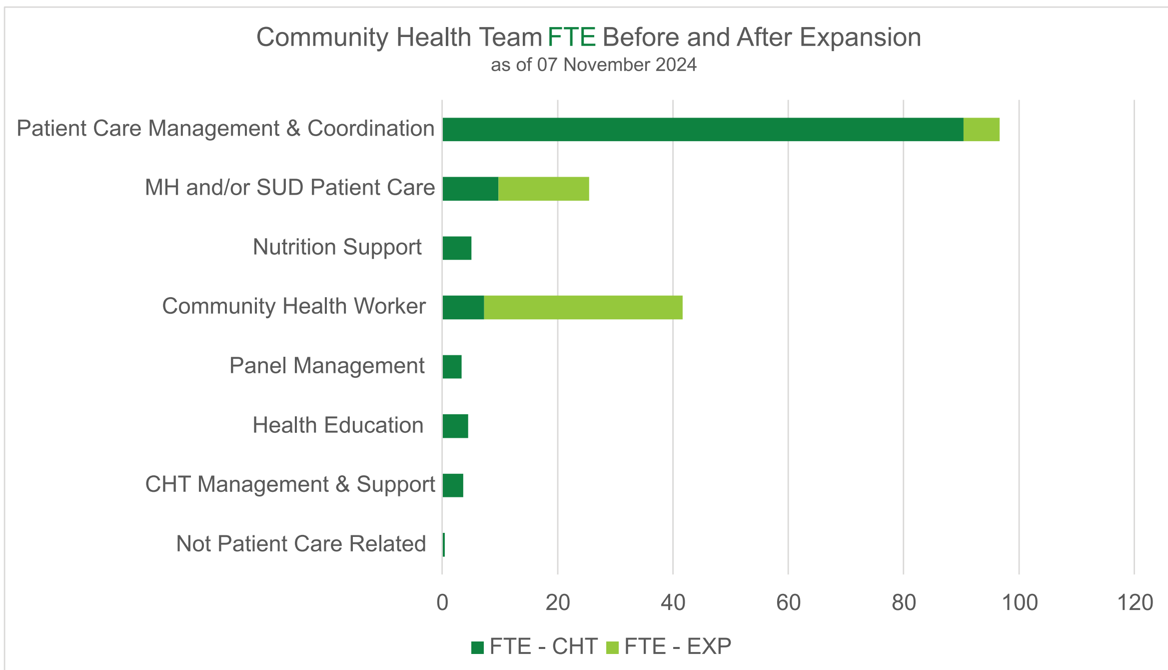
The specialized QI facilitator hosted a Community Health Team (CHT) Learning Collaborative Pilot as part of CHT expansion quality improvement (QI) efforts in support of being a learning health system. The learning collaborative method was identified as an opportunity for sharing how Administrative Entities (AEs) implement the CHT model in their communities, their successes, and their challenges. The learning collaborative prompted peer-to-peer sharing about their strengths and challenges related to the major components of CHT program administration.

QI Facilitators' work with Pregnancy Intention Initiative practices focused on support for assessing and setting goals related to integration of the program, connectivity with the Vermont Health Information Exchange, and supporting continuous quality improvement efforts at each practice.

C. Community Health Team Data

Along with the PCMH model, CHTs are integral to the success of the Blueprint. These teams, funded by commercial and public payers, provide services to patients who are not generally covered by insurance. A CHT member can provide screening, brief intervention, referral to treatment, care coordination, education, and self-management support, among other interventions. The Blueprint CHTs strive to provide person-centered care to all Vermonters. It is essential that the CHTs work with community partners as a team to support patients as part of each person's care plan, especially those with complex physical and social needs. These services are provided free of charge and without regard to insurance status. The types and distribution of CHT staff members in 2024 are highlighted below. The graphs show the immediate impact of the CHT Expansion Pilot on increasing staff in critical areas. Evaluation of the impact of the Pilot will proceed as the CHT Expansion Pilot continues through its second year.





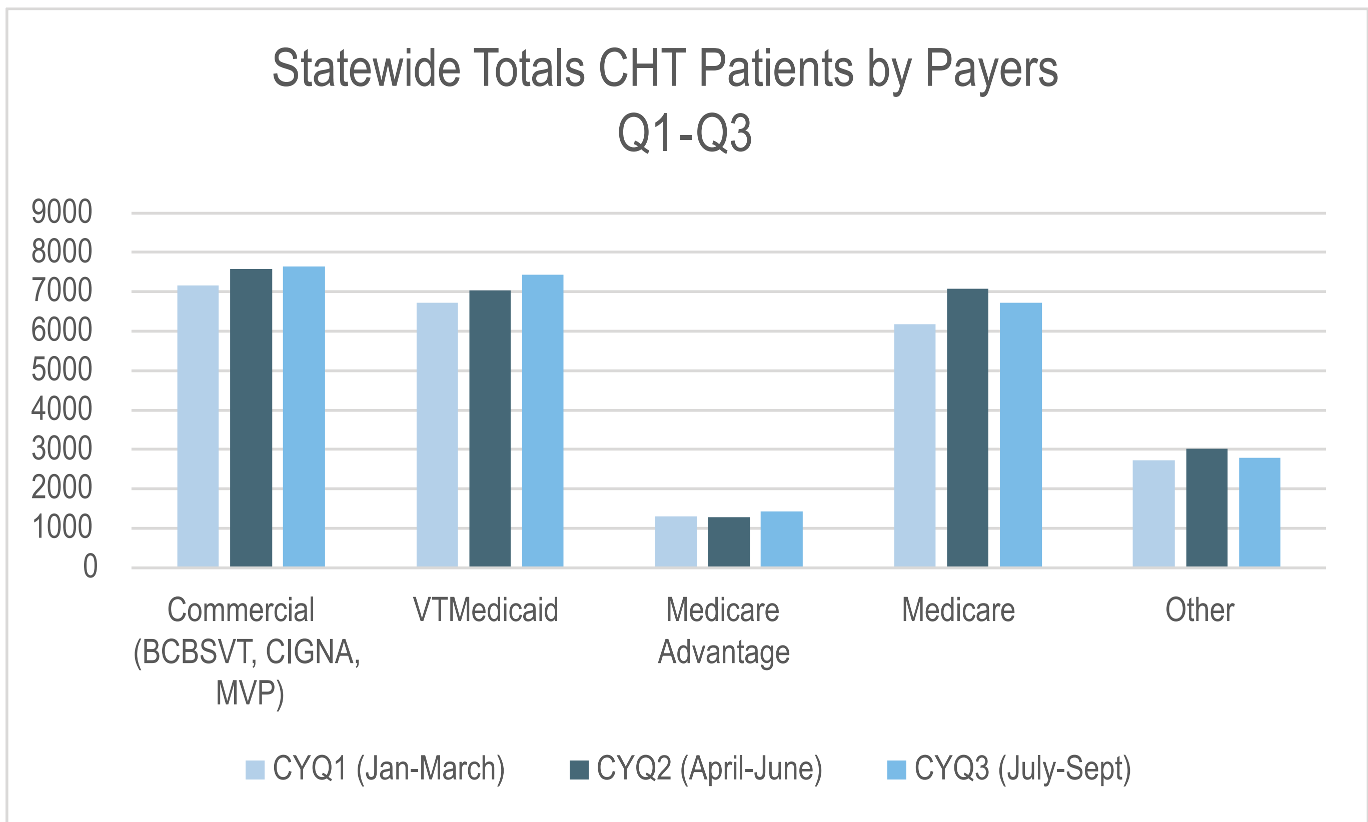
In 2022, the Blueprint began to track the numbers of patients served by CHT staff, including their insurance type where possible, for the first time. This information indicated that Community Health Teams serve individuals with a variety of insurance types, highlighting the importance of the Blueprint's universal approach. The Blueprint will continue to build the capacity to track patients, encounters, and payers without compromising patient confidentiality.

Blueprint CHT Patient Counts By Payer By Health Service Area
Calendar Year 2024 Q1-Q3

Health Service Area	Calendar Quarter	Commercial (BCBSVT, Cigna, MVP)	VT Medicaid	Medicare Advantage	Medicare	Other
Barre	CYQ1 (Jan-March)	319	435	224	555	148
Barre	CYQ2 (April-June)	287	387	236	530	123
Barre	CYQ3 (July-Sept)	250	384	237	529	128
Bennington	CYQ1 (Jan-March)	334	451	20	187	203
Bennington	CYQ2 (April-June)	170	407	11	298	157
Bennington	CYQ3 (July-Sept)	200	316	0	205	213
Brattleboro	CYQ1 (Jan-March)	73	116	78	211	67
Brattleboro	CYQ3 (July-Sept)	151	166	71	411	97
Brattleboro	CYQ2 (April-June)	153	111	41	401	67
Burlington	CYQ1 (Jan-March)	4558	2589	600	1318	833
Burlington	CYQ2 (April-June)	5003	2865	680	1736	777
Burlington	CYQ3 (July-Sept)	4778	2866	755	1606	714
Middlebury	CYQ1 (Jan-March)	531	281	275	605	171
Middlebury	CYQ2 (April-June)	386	311	195	379	110
Middlebury	CYQ3 (July-Sept)	502	484	225	444	165
Morrisville	CYQ1 (Jan-March)	237	185	0	282	113
Morrisville	CYQ2 (April-June)	267	172	0	394	124
Morrisville	CYQ3 (July-Sept)	315	297	0	438	128
Newport	CYQ1 (Jan-March)	86	110	0	173	81
Newport	CYQ2 (April-June)	124	136	0	202	117
Newport	CYQ3 (July-Sept)	129	132	0	314	116
Randolph	CYQ1 (Jan-March)	37	63	21	47	9
Randolph	CYQ2 (April-June)	61	92	16	77	26
Randolph	CYQ3 (July-Sept)	67	120	18	86	28
Rutland	CYQ1 (Jan-March)	166	1040	37	558	96
Rutland	CYQ2 (April-June)	140	970	42	504	52
Rutland	CYQ3 (July-Sept)	126	860	29	433	45
Springfield	CYQ1 (Jan-March)	57	97	47	98	71
Springfield	CYQ2 (April-June)	45	72	57	86	53
Springfield	CYQ3 (July-Sept)	110	106	99	128	86
St. Albans	CYQ1 (Jan-March)	196	453	0	564	257
St. Albans	CYQ2 (April-June)	200	536	0	641	309

continued on next page

Health Service Area	Calendar Quarter	Commercial (BCBSVT, Cigna, MVP)	VT Medicaid	Medicare Advantage	Medicare	Other
St. Albans	CYQ3 (July-Sept)	308	732	0	554	408
St. Johnsbury	CYQ1 (Jan-March)	402	735	0	1109	446
St. Johnsbury	CYQ2 (April-June)	521	833	0	1467	689
St. Johnsbury	CYQ3 (July-Sept)	543	822	0	1281	565
Windsor	CYQ1 (Jan-March)	159	170	0	471	230
Windsor	CYQ2 (April-June)	232	153	0	364	422
Windsor	CYQ3 (July-Sept)	155	149	0	291	91



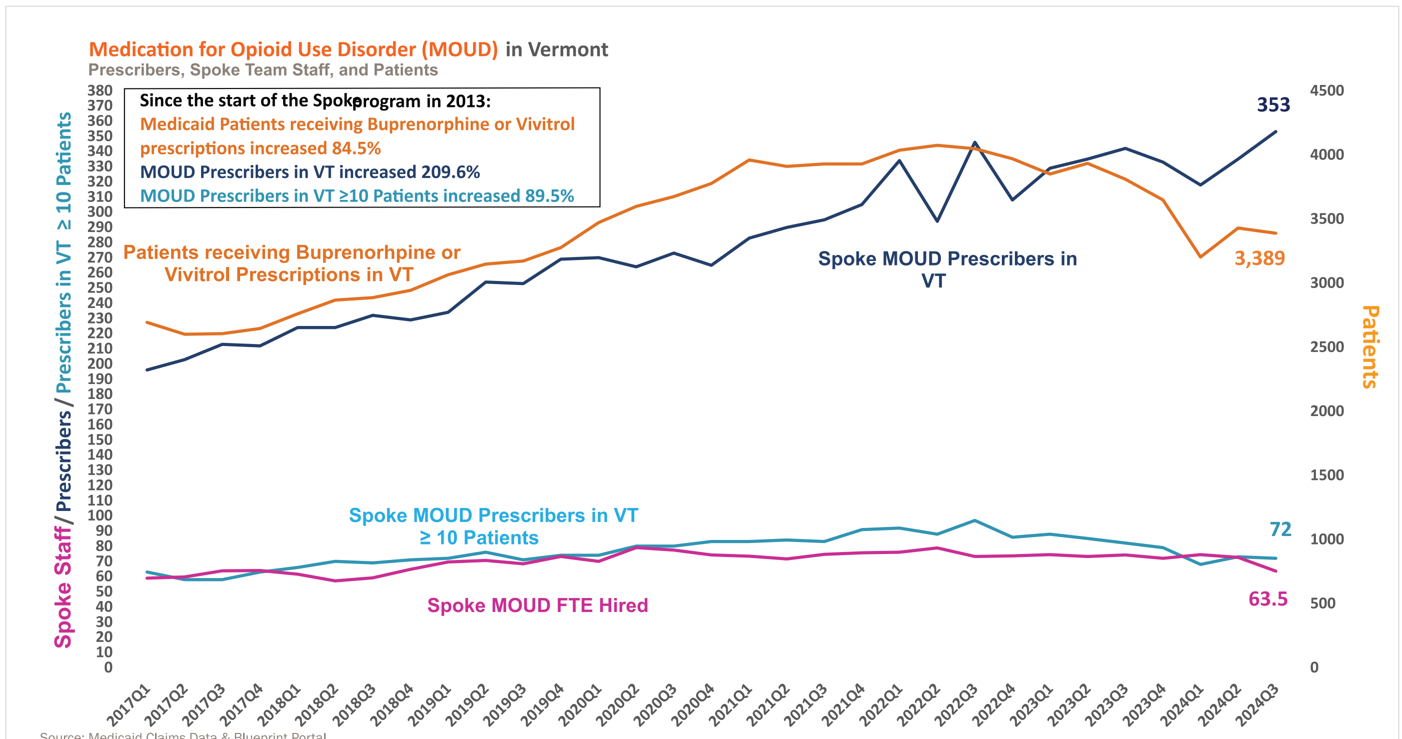
D. Hub & Spoke

Hub & Spoke is Vermont's system of medication for opioid use disorder (MOUD) supporting people in recovery from opioid use disorder (OUD). The Department of Health and the Blueprint for Health have had a longstanding collaborative relationship. MOUD providers, recovery coaches, and partners share expertise and continue to improve the system of care and the health and wellbeing of Vermonters.

The Blueprint administers the Spoke part of the Hub & Spoke system of care, while the Department of Health administers the Hubs. For every 100 Medicaid patients that are prescribed buprenorphine or Vivitrol® (a long-acting injectable form of naltrexone), the Blueprint supports communities to hire a full-time nurse and mental health clinician to embed in practices that prescribe MOUD.

The Blueprint contracted with the Center for Technology and Behavioral Health at Dartmouth College for Substance Use Disorder and Mental Health Learning Collaboratives provided to Blueprint practices and the Hub & Spoke OUD care network. The curriculum, delivered from September 2023 through July 2024, included eleven virtual monthly webinars and workshops and an in-person conference. Five webinars featured nationally renowned presenters including the first federal Assistant Secretary of Health and Human Services for Mental Health and Substance Use Elinore F. McCance-Katz, MD, PhD. Six virtual workshops featured Vermont-based content experts providing care in a range of settings including Federally Qualified Health Centers, Designated Agencies, Emergency Departments, and the Vermont Department of Corrections. An average of 72 Vermont care-team members and affiliated service providers attended each virtual event. Attendees to the Whole Person Care: Enhancing Substance Use Disorder & Mental Health Treatment Conference numbered 173 with every Health Service Area represented by between six to 30 Vermont professionals. Internationally known clinician/researcher and author Frances Jensen, MD, provided a plenary titled "Substance Use in the Adolescent Brain: What Neuroscience Can Tell Us." Other national and regional presenters represented a range of clinical roles including people with lived experience receiving care.

Vermont continues to demonstrate substantial access to MOUD by funding registered nurses and licensed, Master's-prepared, mental health/substance use disorder clinicians as a team. These Spoke teams offer evidence-based treatment and provide Health Home services for Vermonters with opioid use disorder. The Blueprint continues to encourage the use of VT Help link, a free and confidential referral service available to connect people to resources and treatment (802-565-LINK or Vermont Help Link).



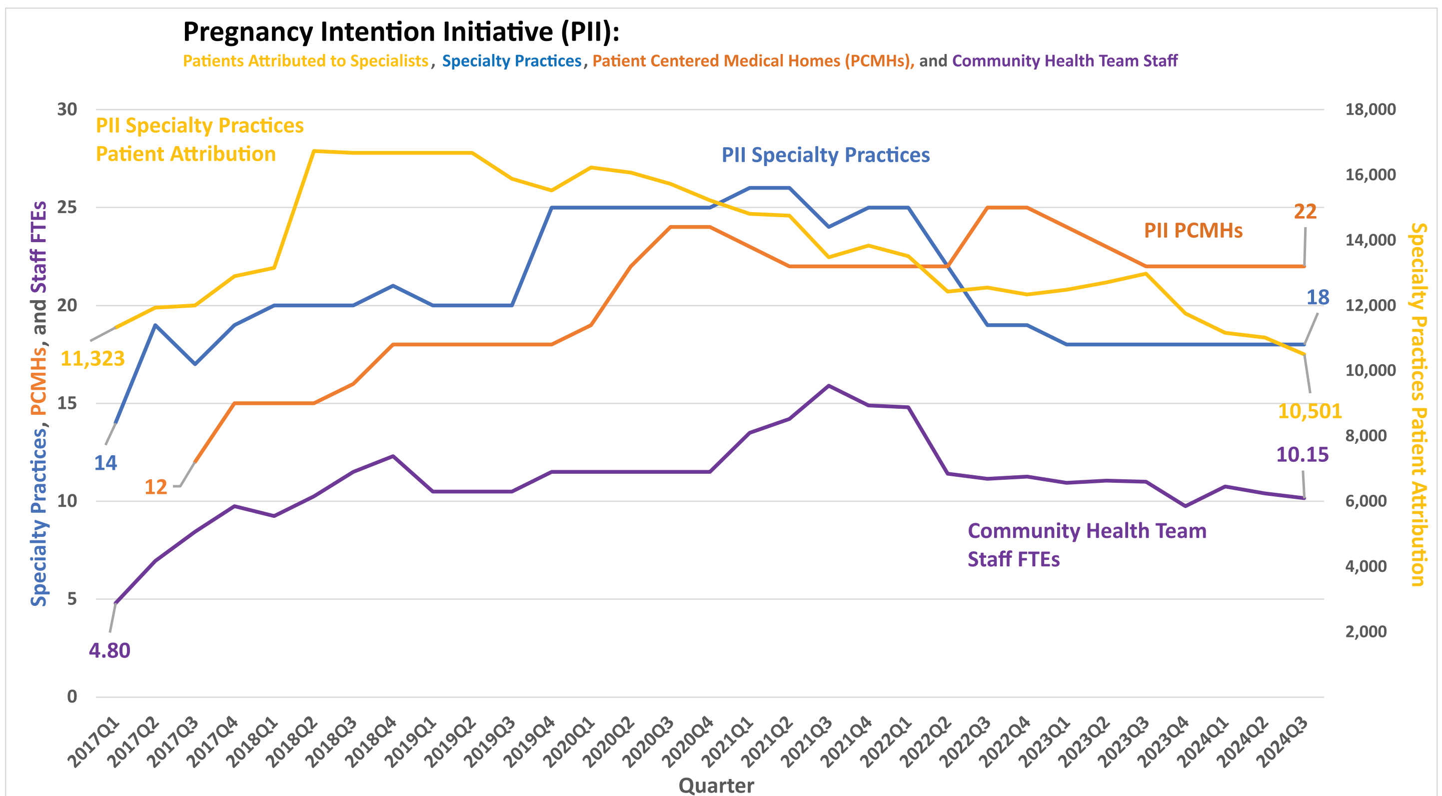
Source: Medicaid Claims Data & Blueprint Portal

E. Pregnancy Intention Initiative (PII)

(formerly Women's Health Initiative)

The Pregnancy Intention Initiative strives to support people who can become pregnant in their efforts to experience healthy pregnancies, avoid unintended pregnancies, and build thriving families. The PII provides mental health staffing at specialty practices and utilizes the existing CHT at participating Blueprint PCMH practices. If an individual 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. If a person would like to become pregnant, they receive support for a healthy pregnancy. The practice screens for social drivers of health such as food security, housing security, interpersonal violence, depression, anxiety, harm to self or others, mental health issues, and substance use. Positive screens are addressed with brief interventions and treatment by the embedded PII mental health clinician if indicated. These clinicians also communicate programmatic information to community partners to build meaningful relationships, support patients more closely, and create seamless transitions of care when referral is necessary.

The Blueprint holds in-person hands-on trainings two to four times per year to support the PII network of providers in contraceptive care. In collaboration with the University of Vermont, Dr. Lauren MacAfee trained more than 50 providers this year from Blueprint PII sites on LARC insertion and best practices around patient choice of contraception in the past year.



F. Self-Management Programming

The Blueprint and the Vermont Department of Health maintain a Memorandum of Understanding to work closely together for the provision of Self-Management Programming through My Healthy Vermont workshops. While the Blueprint still provides the funding and oversight of the programming, the Health Promotion and Disease Prevention (HPDP) unit within the Department of Health administers the programs through grants to local hospitals and Federally Qualified Health Centers (FQHCs). This partnership takes advantage of the additional funding and content expertise that exists within HPDP through the My Healthy Vermont program, and pairs it with Blueprint's influence at the local level. During 2024, the Blueprint worked with the Department of Health in the evolution of the "regional coordinator" model to one prioritizing local staff with specialized statewide roles, called "engagement specialists." This change aims to improve efficiency and effectiveness in the administration of the programs, enrollment of participants, and connections with primary care and specialist practices.

The six types of Self-Management Programs offered during 2024 include:

- Blood Pressure Management
- Chronic Disease Management
- Chronic Pain Management
- Diabetes Self-Management Program
- Diabetes Prevention Program
- Quit Smoking

From October 2023 through September 2024, the Department of Health and the Blueprint offered 71 workshops, with a total of 293 individuals completing a program. The Diabetes Prevention Program had the largest numbers of workshop completers.

G. Potential Future Medicare Participation Changes

In December of 2025, the current all-payer model agreement with the Centers for Medicare and Medicaid Services (CMS) will end. This agreement has allowed Medicare to participate in the Blueprint by contributing practice payments and Community Health Team (CHT) payments. Once the agreement ends, Medicare will no longer be able to contribute payments to Blueprint programs unless another agreement with CMS is signed. The only available CMS agreement at the time of this report is the AHEAD model. If the State of Vermont chooses not to move forward with the AHEAD agreement, Blueprint Patient-Centered Medical Homes (PCMHs) and Community Health Teams will lose over $5 million dollars annually in Medicare payments. This is approximately one-quarter of the total annual funding for Blueprint practices and CHTs. The loss of this funding could result in a reduction in CHT staff by up to one-quarter, decreasing the availability of CHT services to Vermonters. Along with the loss of funds to the Blueprint program, the SASH program will also lose about $5 million with this change. The Blueprint is working with AHS partners to determine a path forward to navigate these potential funding changes.

H. Performance Audit

In 2024, the State Auditor's Office (SAO) conducted a performance audit of the Vermont Blueprint for Health with the collaboration with the Blueprint team. The SAO focused on the Blueprint's annual reports to the legislature and statutory requirements. The Blueprint team anticipates the SAO report will be published in February, 2025. Based on the findings from this audit, Blueprint expects to implement reforms to address the findings identified by the SAO and will provide additional information on the steps it will undertake in response to the SAO's findings following the publication of the report.

V. EVALUATION

A. Health Care Measurement Results for Blueprint Target Populations

1. Health Care Claims and Clinical Data

Since its inception, a core mission and statutory responsibility of the Blueprint has been to support service delivery reform and track 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 previous all-payer analytics contract. Calendar Year (CY) 2022 is the latest year for which Blueprint has multi-payer, population-level health care measurement data for Vermont. The following annual health care 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 database managed by the GMCB. Clinical/hybrid measures used clinical data from 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 2022 community health profile measures are posted on the Blueprint for Health website.

Populations of Analysis

Consistent with prior annual reports, results are presented for the wider primary-care service target population of VHCURES members (i.e., individuals enrolled 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 attribution. In 2022, this VHCURES data represented 455,415 people, or 70.4% of Vermont's 2022 population.

Due to the 2016 *Gobeille vs. Liberty Mutal Insurance Company* Supreme Court Decision, self-insured plans are not required to submit data to VHCURES. 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 health care outcomes for over 450,000 Vermont residents.

2. Population Counts and Demographics

Statewide Demographics	CY 2022	CY 2022
Vermont Legislative Joint Fiscal Office Statewide 2022 Population Estimate: 647,064	Total VHCURES (Excluding Self-Insured) Members	Blueprint PCMH Primary Care Attributed Members
Population N	455,415	260,573
Avg. Age	44.9	43.2
% Female	52.00%	54.00%
% Medicaid	33.00%	34.00%
% Medicare	31.00%	29.00%
% Commercial	36.00%	37.00%
% ACG* Healthy Users	8.00%	8.00%
% ACG* Low Risk	12.00%	14.00%
% ACG* Medium Risk	41.00%	45.00%
% ACG* High Risk	16.00%	17.00%
% ACG* Very High Risk	9.00%	10.00%

*ACG risk scores refer to the Johns Hopkins Adjusted Clinical Group risk stratification methodology. The sum of the ACG risk percentages is less than 100% because not all patients receive an ACG risk score due to a lack of claims.

Evaluation measure results are presented in the appendix of this report. In those results, regional breakouts are based on Vermont Department of Health HSA4 Hospital Service Areas. A map of these Hospital Service Areas can be found by filtering with the layers widget at this Vermont Department of Health website.

B. Expenditures for the period

1. Blueprint Expenditures

Blueprint for Health Annual Budget by Program Elements and Funding Source

Blueprint Program Elements	Annualized Budget	Description	Money Flow	Participation
Patient-Centered Medical Home (PCMH) Payments	$11,876,488	PCMH Per Member Per Month (PMPM) Quality Payments to Practices for NCQA Recognition	From Payers to Practices (Parent Organizations)	All Payers (Includes Medicare)
Community Health Teams (Core/Primary Care)	$9,897,159	Teams support PCMH practices and interface with community services	From Payers to Local Hospital (or FQHC)	All Payers (Includes Medicare)
CHT Expansion Pilot CHT Staff	$6,455,267.28	Embedded MH/SUD and SDOH support for PCMH practices	From payers to local FQHC or Hospital	Medicaid - Pilot funding
DULCE Family Specialists	$418,398.90	Embedded Family Specialists following the DULCE model in six pediatric practices	From payers to local FQHC or Hospital	Medicaid - Pilot funding
DULCE Administrative Funding for VDH	$425,080	Memorandum of Understanding with the Department of Health	Administrative costs	DVHA/Medicaid - Pilot funding
Spoke Staff (Extended CHT)*	$6,607,312.50	RN and Mental HealthCounselor teams support MOUD prescribers	From Payer to Local Hospital (or FQHC)	DVHA/Medicaid
PII PMPM Payment to Specialty Practices	$142,197.50^	Attestation to program elements	From Payer to Practices	DVHA/Medicaid
PII PMPM Payment to PCMH Practices	$62,021.25^	Attestation to program elements	From Payer to Practices	DVHA/Medicaid
PII One-Time Practice Payments	$0	Workflow changes for screening, same-day long-acting reversable contraception	From Payer to Practices	DVHA/Medicaid
PII Staffing (Extended CHT)	$833,967	Staff for brief interventions and navigation to services	From Payer to Local Hospital (or FQHC)	DVHA/Medicaid
PII Program Management	$21,750.00	Program Administration, staff supervision, Travel and training	Grant to PPNNE	DVHA/Medicaid
Program Management	$1,446,250	Change management and program administration	Grant to Local Hospital (or FQHC)	DVHA/Medicaid
Quality Improvement Facilitators	$1,100,000	In-practice QI coaching for NCQA, ACO priorities, and practice priorities	Grant to Local Hospital (or FQHC) or Contract w/QI facilitator	DVHA/Medicaid
Physician Clinical Consultant	$19,308	Provision of clinical expertise for planning and evaluation	Contract with Vendor	DVHA/Medicaid
Community Self-Management Programs	$664,163	Memorandum of Understanding with Department of Health to support local Self-Management Programs	VDH grants to Local Hospital (or FQHC)	DVHA/Medicaid
Training Contracts/ Grant(s)	$13,100 $184,983 $100,000 $4,200 $2,400	PII Trainings by UVM Faculty Dartmouth Spoke Provider Trainings Center for Health and Learning Care Transformation Collaborative - Rhode Island Pride Center of Vermont	Contracts with Vendors	DVHA/Medicaid VDH Medicaid - Pilot Funding Medicaid - Pilot Funding Medicaid - Pilot Funding

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Health IT Grant for staffing to manage Support and Services at Home (SASH) care management system	$205,000	Grant to administrative entity for the Vermont SASH program, for staffing.	Grant to Senior Housing Organization	DVHA/Medicaid
Data and Analytics Contracts				
All-Payer and Medicaid Analytics	$604,600	Program evaluation for performance payments and for State and Federal reporting	Contract with Vendor	DVHA/Medicaid
Patient Experience of Care Survey	$239,101	Survey of Vermonters served in primary care in accordance with statute	Contract with Vendor	DVHA/Medicaid
Qualitative Analysis of CHT Expansion Pilot	$98,733	Program evaluation for CHT Expansion Pilot	Contract with Vendor	Medicaid - Pilot Funding
Quantitative Analysis of CHT Expansion Pilot	$260,152	Program evaluation for CHT Expansion Pilot	Contract with Vendor	Medicaid - Pilot Funding

* Vermont Department of Health manages Hubs ^Fourth quarter data is not yet available for PII PMPM payments, therefore an estimated fourth quarter dollar amount was used when calculating annual PII PMPM costs.

C. Results of patient and provider satisfaction surveys

The Blueprint for Health (Blueprint) annually reports the patient experience of care as required by Vermont Statute. Since 2011, this task has been fulfilled through the administration of the Consumer Assessment of Healthcare Providers (CAHPS) Clinician and Group Survey with Patient-Centered Medical Home (PCMH) questions included. The outcomes for this survey [PDF] provide the broadest statewide look at patient experience of primary care in Vermont. The number of practices that participated in the 2023 survey was 122, a slight decrease from the 128 participating practices of 2022. A total of 65,980 surveys were distributed with 9,929 adult and 1,690 pediatric patients providing responses. The combined response rate was 17.6%, slightly lower than the 2022 response rate of 21.3%. Despite this lower overall response rate, the 2023 survey had the largest number of pediatric respondents of any survey in the past five years.

The results of the CAHPS survey 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.

V. HEALTH SERVICE AREAS

The Blueprint staff in each Health Service Area (HSA) are responsible for the continued success of the program and have worked during 2024 to address the ongoing needs of their communities. The following section of the report includes information provided by each HSA.

Blueprint Leadership Gathering October 17, 2024 at the Waterbury State Office Complex

BARRE HEALTH SERVICE AREA

Program Manager: Constance Gavin

At a Glance

49,767	Health Service Area Total Population
30,777	Blueprint Practices Patient Attribution
4,772	Community Health Team Patient Count*
147	Spoke-Eligible Patient Population‡
10.14	Community Health Team Staff FTE
3.02	Spoke staff FTE
.5	Pregnancy Intention Initiative Staff FTE

* Community Health Team Patient Count (January–September, 2024—may include duplicates)
‡ Spoke Eligible Patient Population (Average July–September 2024)

COMMUNITY HEALTH TEAM

Composition and Expanding Access

In the Barre Health Service Area, 5.69 FTEs have been hired through the Expansion Pilot. Expansion-funded positions are exclusively patient-facing, non-billing individuals who connect patients with community resources and/or provide brief intervention for Vermonters with substance use disorder and/or mental health concerns.

Care Coordination and Team-Based Care

Members of the Community Health Team (CHT) participate in team-based care collaboration opportunities including: Adult Local Interagency Team (LIT), housing coordination, Rapid Access to Medication (RAM) for Opioid Disorder (MOUD) treatment HUB-Soke meetings, Central Vermont Community Response Team (CVCRT) care coordination meetings, and the Washington County Domestic Violence Coordinated Community Response (Circle CCR).

> "The work we are able to provide is critical to the support of patients and our providers in our local spokes. I have had primary care providers tell me this is the most rewarding aspect of their job, and patients say you've helped save my life.
>
> —Primary Care Spoke Counselor

> "The impact of resourceful contacts that Blueprint has offered has provided us with additional tools to provide to patients in need of these services whether it's an attempt to quit smoking or anxiety/depression. Having these tools allows us to approach each patient with confident integration so they can be set up for success long term instead of just a quick leap of faith.
>
> When our community is strong, we are stronger as a practice."
>
> —Provider at Blueprint PCMH, Barre HSA

ACHIEVEMENTS and ACCOMPLISHMENTS

THRIVE Flood Response and Impact Report

THRIVE, the Barre HSA Accountable Community for Health created a shared register inclusive of partner contact information, crisis updates, flood resources, and community needs. The group drafted a 2024 *THRIVE Flood Impact Report* offering retrospective insights about the crisis response, documented lessons learned and proposed recommendations for the group to carry forward. The Vermont Public Health Association invited THRIVE to submit for a Population Health Group Award (status pending).

Central Vermont Addiction Recovery Resource Guide

The Blueprint team, in participation with the Central Vermont Prevention Coalition, developed and distributed the *Central Vermont Addiction Recovery Resource Guide* in response to a new Agency of Human Services (AHS) "Interdiction" protocol. Following the initial interdiction meeting, questions from partners emerged, specifically from law enforcement, first responders and landlords, seeking handouts with referral information for impacted people to inform them about addiction treatment programs and resources in the region.

> "There is a provider shortage, and practices across the state are overwhelmed. There are many competing demands on primary care as the patients' medical homes. Still, expanding screenings is something we are committed to doing. We know it is important to serve our people beyond sick care. When serving patients with several health challenges, it can be hard to fit in screenings. The question is how to integrate screening in a way that works, making it as easy as possible. We're looking at getting patients in for a well care visits to complete screenings. We want to make it work smoothly, working with our electronic medical record. Having Blueprint funding to hire the Community Health Team staff to support screenings is allowing us to look at reaching out to patients to schedule well visits, conduct screenings and work with our EMR to gain efficiency to accomplish these goals."
>
> —Chief Executive Officer and Medical Director at The Health Center, Plainfield

Care Transformation Collaborative—Rhode Island Think Tank Presentation and Consultation

The Barre HSA Blueprint team coordinated consultation and a presentation from the Central Vermont Medical Center ROAD (Response to Alcohol Addiction) initiative at the request of the Blueprint Executive Director, Dr. John Saroyan.

KEY QI WORK

Supporting Patient-Centered Medical Homes to meet NCQA standards

The Blueprint QI Facilitator supported all 10 HSA practices with PCMH annual renewals. For UVM Health Network (UVMHN) practices, there has been significant work to standardize NCQA criteria across the network to improve care quality, consistency, accreditation, patient experiences, efficiency, and to support data-driven decisions. All eight Central Vermont Medical Center and the two independently owned practices maintained NCQA PCMH this year.

UVMHN also chose key performance improvement measures to align the Network High Value Care priorities with PCMH quality measures including depression screening, diabetes A1C control, Hypertension blood pressure control, and colorectal cancer screening.

Additional quality improvement efforts supported by the QI Facilitator at the network level included:

- targeted outreach to patients with unprocessed kits to increase colorectal cancer screening
- centralization of transitions of care follow-up calls
- prioritization and outreach to patients with no upcoming appointment scheduled within the targeted time frame based on comprehensive risk stratification and other key data points including priority care gaps (which align with the quality measures outlined above), unaddressed conditions from prior year (indicated by high open Risk Adjustment Factor [RAF] values/uncoded Hierarchical Condition Category [HCC] conditions).

Year 2 CHT Expansion Pilot Implementation

UVMHN adopted Blueprint and OneCare recommended ACH-HRSN tool (CMS 16). The new screening was built and launched in the electronic health record (EHR). Following the expansion of health-related social needs (HRSN) screenings (formerly Social Determinants of Health), the UVMHN CHT noted a significant increase in positive screenings and the number of referrals for follow up. Tree of Life requested monthly consultation focused on expanding depression and suicide screenings. The Health Center reports a planned launch of the CMS 10 in March 2025.

"I appreciate the opportunity to work in a collaborative effort with patients and providers in offering education, guidance, and medication management to reduce risk in our community and support healthy function. One of the most rewarding parts of my jobs is to be witness to someone else's growth in their recovery journey."

—Primary Care Spoke Counselor

FUTURE GOALS

Team-Based Care (TBC) Approaches that minimize duplication of services

Team-Based Care in Partnership with the Camden Coalition

In the Barre HSA, we aim to improve coordination of care by defining types of care coordination/management; designing an ecosystem map of Barre TBC structures that outlines services authored, points of contact, funding and referral pathways; and developing a process for collaborating on the most complex cases.

Addressing chronic disease management, reducing deaths by overdose/suicide, and assisting patients accessing primary care and specialty care

Chronic disease management

In 2025, all UVMHN practices will focus on improving diabetes A1C control and controlling high blood pressure by implementing evidence-based care pathways, enrolling patients in a chronic disease focused care management program, and actively reaching out to patients with chronic-disease related care gaps.

My Healthy Vermont

This year the Provider Outreach Specialist (formerly Regional Coordinator) published a newsletter celebrating the top primary care provider referral offices. Looking to the future, the Blueprint and Self-Management teams are exploring opportunities to leverage employee wellness programs as venues for workshop recruitment. The workshops are a great addition to worksite wellness programs, and they are available at no-cost to participants—a tremendous value.

Reducing Death by Overdose/Suicide

UVMHN participated in the ZeroSuicide grant and formed a network workgroup. The workgroup recommended universal Columbia Suicide Severity Rating Scale (C-SSRS) screening at adult annual wellness visits. The pathway is in pilot phase at several clinics across the network for further review and implementation. At Central Vermont Medical Center (CVMC), the staff psychologist completed the evidence based Collaborative Assessment and Management of Suicidality (CAMS) training, and the Waterbury Nurse Manager completed the Essential ZeroSuicide trainings. Additionally, the network developed a provider- and patient-facing *CVMC Behavioral Health Resource* flyer. The Blueprint Program Manager and QI Facilitator provide monthly consultation for the two independent practices sharing resources, training opportunities, and lessons learned to support their ongoing efforts to expand suicide screenings and follow up.

Accessing Primary and Specialty Care

CVMC, as part of the UVMHN, is committed to creating an exceptional experience for employees and patients. Improving access to care is one of the Network's goals for the year ahead along with increasing the value and affordability of care and delivering safe, effective, and equitable care.

"We made great strides this year in PII. Most importantly, UVMHN pediatrics practices have embedded the One Key Question into all annual wellness visits. I'm so pleased pediatric leadership understand the importance of this initiative!"

—PII Team member

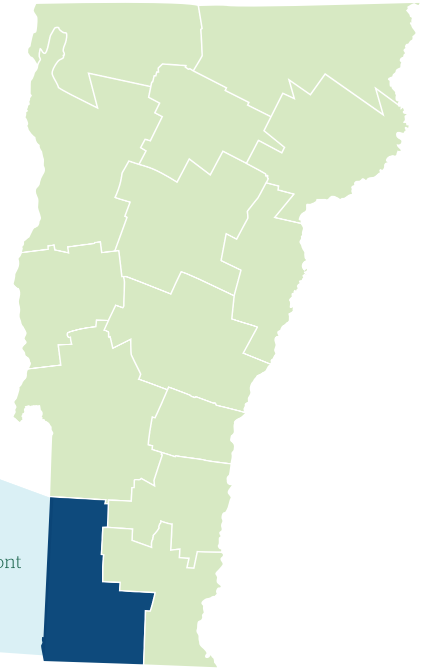
BENNINGTON HEALTH SERVICE AREA

Program Manager: Todd Salvesvold

At a Glance

29,312	Health Service Area Total Population
14,821	Blueprint Practices Patient Attribution
3,172	Community Health Team Patient Count*
362	Spoke-Eligible Patient Population‡
6.4	Community Health Team Staff FTE
6.15	Spoke staff FTE
1.0	Pregnancy Intention Initiative Staff FTE

* Community Health Team Patient Count (January–September, 2024—may include duplicates)
‡ Spoke Eligible Patient Population (Average July–September 2024)



COMMUNITY HEALTH TEAM

In 2024, the Bennington CHT served 14 practice locations across the Health Service Area (HSA). These practices include one Federally Qualifed Health Center (FQHC), five hospital-owned practices, six independent practices, and two specialty care offices (OBGYN and SaVida Health). Included in this total, Bennington Blueprint for Health supported four Patient-Centered Medical Home (PCMH) sites that provided Medications for Opioid Use Disorder (MOUD) services in addition to primary care, and two PCMH sites that participated in PII. However, it should be noted that Dr. Seyferth closed his office in August 2024 and is no longer part of the Blueprint. Yet, it is also important to note that Dr. Burdick, formally of SVMC Pownal, has begun practicing in the location previously occupied by Dr. Wood and has begun the process to become established with Blueprint.

The Bennington CHT also provided the support of a Registered Dietician and Community Health Navigator who followed a centralized support model for the Bennington HSA. These staff identified community members in need of services via a referral system generated by providers, peers, and patients themselves.The CHT team members collaborate across agencies and disciplines to ensure effective care coordination of routine and complex care, specifically around care transitions. This is highlighted by the formalization of care planning documentation within the electronic medical records (EMR) system of Southwestern Vermont Medical Center (SVMC). Care recommendations created by Blueprint staff become an active part of a patient's treatment plan and viewable to all, whereas previous RN documentation was done in a separate section of the EMR and not readily available.

ACHIEVEMENTS and ACCOMPLISHMENTS

Our CHT team continues to work diligently to build relationships with interdisciplinary teams to have a positive impact on patient care and outcomes. One key area of work has been around reducing the number of individuals who may board in acute care setting awaiting long-term care placement due to unmet needs that prevent them from remaining in the community setting. Warm-handoffs with hospital-based care teams, PCP teams and numerous community agencies have allowed for development of short-term plans that allow for the patient to return to their home with adequate support services while the numerous details involved in long-term care planning can be navigated with this team. Some of these individuals have been able to remain in the home-setting with these additional support services and navigation instead of having to leave their home.

Our Pregnancy Intention Initiative (PII) program continues to be highly utilized within the service area and has established a significant link to the Spoke team. As providers in the SVMC office have expressed concerns about the health and well-being of pregnant

and post-partum women who are also struggling with a substance-use disorder and/or prescribed MOUD, a care coordination meeting has been established between the two programs to support patient needs. This meeting is held on a monthly basis and also includes OBGYN and Pediatric RNs, as well as providers and office managers.

Sarah McClain, our QI facilitator, focused heavily on the continued relationship development and engagement with each practice in the service area. Sarah supported each office with CY23 reporting and documentation to ensure continued PCMH status. In addition, Sarah works closely with offices to be sure they are aware of upcoming changes in 2024, specifically in the areas of EMR system alignment and office workflows. Sarah is also supporting the PCMH and Blueprint enrollment of Dr. Burdick (formally Drs. Wood and Hearst). Lastly, Sarah is anticipating the enrollment of BeWell Primary Care (formally Brookside Pediatrics) with an expected 2025 first- or second-quarter entry into the Blueprint system.

Community Health Worker (CHW), therapy and social work support has been added to the service area by way of the Blueprint Expansion. In the Battenkill Valley Health Center, a full-time CHW has been added to assist the practice. One CHW FTE has been added to support both the SVMC Pownal and Internal Medicine offices, and one MSW FTE now supports the SVMC Northshire office. One MSW FTE began supporting the SVMC Pediatrics office on December 2nd of this year. Furthermore, Mount Anthony Primary Care has received an additional 0.2 FTE support from a licensed therapist.

Bennington Blueprint maintains an active role with Project Alliance, which was established to focus on areas of concern in the service area, namely prevention, treatment, recovery and criminal justice. Members of the Leadership Team include: Agency of Human Services, Alliance for Community Transformation, Bennington Blueprint, Bennington State's Attorney, Center for Restorative Justice, Department of Children and Family Services, Department of Health—Bennington District Office, SaVida Health, Southwestern Vermont Healthcare, Office of the Public Defender, Bennington Sheriff, The Collaborative, Bennington Police, the Turning Point Center, and United Counseling Service. The leadership team has established a mission, vision and goals, assessment, strategies, and prioritized needs. The group continues to meet on a bimonthly basis, with sub-committees meeting monthly.

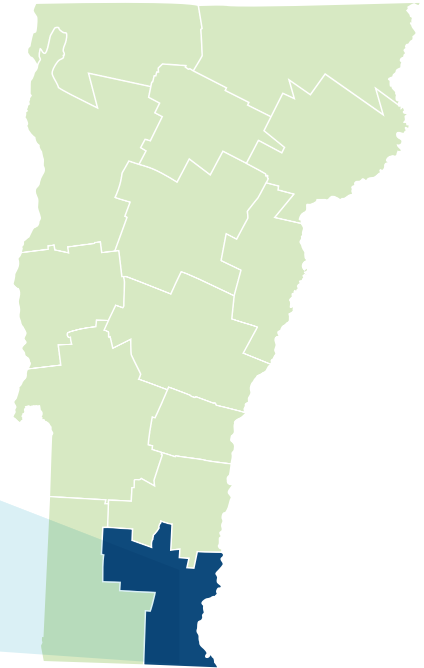
> "While I would always say I was a little depressed as a youth, my mental health definitely got worse by the time I was a teenager. . . . I also had problems with sleep, which made matters much worse. . . . I always had this enormous amount of mental energy and could not turn my brain "off." . . . There were also many physical symptoms; I felt like my heart was beating fast, I would get headaches, and had strong anxiety over nothing. . . . It was not until I met the RN case manager at my primary care office did I finally begin to consider therapy and medication. . . . She connected me to a therapist and a nurse practitioner, and for the first time in my life, I began to feel "normal." The nurse practitioner was able to prescribe me medication that not only slowed my racing thoughts, but also allowed me to get better sleep. My therapist (who I still see to this day) gave me skills to manage my thoughts and emotions, and my headaches occurred less and less. . . . I am extremely grateful for the day I met my case manager, as she taught me it was Ok to ask for help."
>
> —Success story from a Blueprint RN

FUTURE GOALS

Primary Care practices have been routinely administering the Accountable Community for Health (AHC) Health-Related Social Needs (HRSN) Screening Tool, and practices are establishing workflows for implementation of screening for their panels in anticipation of additional CHT staffing to support the navigation to services. While many of the referrals generated have formally been directed to CHT and Spoke team members, additional workflows are being established to direct some of these referrals to Expansion staff when appropriate. By way of our monthly Care Coordination meeting, multiple community partners are engaged in this highly collaborative effort. In addition, Blueprint staff are working with MOUD-prescribing offices to facilitate the administration of the AHC-HRSN across the service area, as an assessment of data indicates that patients receiving a HRSN screening followed by a referral to care management for support demonstrate better treatment engagement rates that those who did not.

BRATTLEBORO HEALTH SERVICE AREA

Program Manager: Rebecca Burns



At a Glance

24,100	Health Service Area Total Population
13,453	Blueprint Practices Patient Attribution
2,214	Community Health Team Patient Count*
138	Spoke-Eligible Patient Population‡
4.45	Community Health Team Staff FTE
2.0	Spoke staff FTE
.5	Pregnancy Intention Initiative Staff FTE

* Community Health Team Patient Count (January–September, 2024—may include duplicates)
‡ Spoke Eligible Patient Population (Average July–September 2024)

COMMUNITY HEALTH TEAM

The Brattleboro Health Service Area (HSA) is unique in that is has two hospitals in the HSA: Brattleboro Memorial Hospital (BMH) and Grace Cottage Hospital. Within the HSA, we have seven primary care practices that are participating in the Patient-Centered Medical Home (PCMH) program and are a combination of private practices and hospital-owned practices. The BMH-owned practices are Brattleboro Family Medicine, Maplewood Family Practice, Putney Family Health, and Windham Family Practice. Grace Cottage has one primary care practice: Grace Cottage Family Health. Brattleboro Primary care is an independent practice with both an Adult Practice and a Pediatric practice.

The Community Health Team (CHT) in the Brattleboro HSA is a decentralized model with staff embedded directly into the practice with pass-through funding. This has allowed practices to prioritize their individual needs with the type of staff they hire to support the practice with CHT funds. Our CHT funds currently support people in the positions of registered dieticians, care coordinators, Spoke counselors and Spoke nurses, a health coach, and social workers.

> “We are able to meet with people who need it, and we are connected right to primary care so they feel comfortable meeting with us. There also isn’t a co-pay for our support so they don’t have to worry about the money component. My schedule is full, which is a great feeling because I know we are helping people, and it wouldn’t be possible without the Blueprint.”
>
> —CHT Staff Member

> “I can’t believe how amazing it is having an embedded social worker in my primary care practices. I feel very lucky to have this support. I really hope this continues because I can’t imagine not having it now. I have seen such great things from my patients who have worked with them. They were able to address the need right in the visit and not have five different follow ups or try to navigate this system.”
>
> —Primary Care Provider

With the CHT expanded program funded in a two-year pilot project, six of the seven PCMH Primary Care practices have embedded additional staff into their practices. These positions consist of mental health clinicians, family support workers, and a community health worker. These embedded positions are providing integrated Team-Based Care in the primary care practices, responding to screenings for depression, substance use disorder, and other health related social needs.

ACHIEVEMENTS and ACCOMPLISHMENTS

This year the Pregnancy Intention Initiative (PII) has continued to provide screening response to practice screenings for key areas of health-related social needs, depression, substance use disorder, and intimate partner violence. In our monthly meetings, including Four Seasons OBGYN, VDH Nurses, Blueprint QI facilitator, and Planned Parenthood, we identified the schools as being a community partner we have not been able to connect with. We are excited and proud to announce we were able to make a meaningful connection with the Brattleboro Union High School. In looking at unplanned/unintended pregnancies this population was an area of opportunity in our community.

FUTURE GOALS

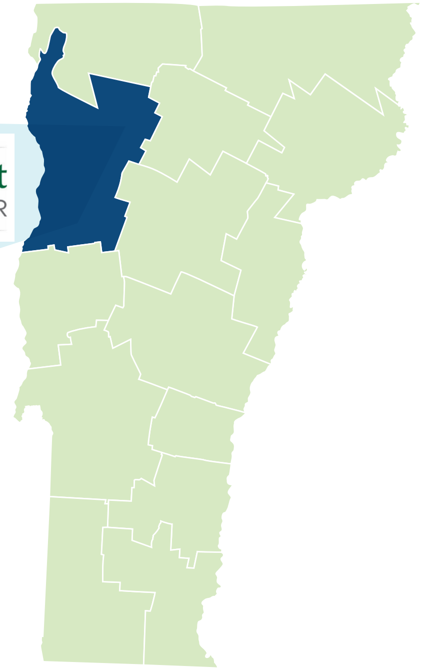
One goal of our community is working with our Accountable Communities for Health (ACH) group in partnership with the Agency for Human Services District Director and with the Camden Coalition in Team-Based Care. We are very excited to be doing this work and looking forward to the roll out of Camden Coalition training materials. This collaboration will work on supporting the All-Payer Model addressing chronic disease management, care coordination and access to services.

Increasing participation from PCMHs in the various programs offered by the Blueprint, such as the PII and CHT expansion program, continue to be goals.

> "Working within an integrative model of care provides the opportunity for mental health clinicians and primary care providers to collaborate in new and exciting ways, leading to better health outcomes across the population. Embedded mental health care has allowed more individuals in our community to access comprehensive support and treatment with little to no wait time and within a team they already know and trust. It's helpful to providers, patients, and the larger healthcare system to work together in this way."
>
> —CHT Expanded Social Worker

BURLINGTON HEALTH SERVICE AREA

Program Manager: Michelle Farnsworth



At a Glance

121,705	Health Service Area Total Population
86,430	Blueprint Practices Patient Attribution
31,678	Community Health Team Patient Count*
719	Spoke-Eligible Patient Population‡
31.1	Community Health Team Staff FTE
15.85	Spoke staff FTE
1.6	Pregnancy Intention Initiative Staff FTE

* Community Health Team Patient Count (January–September, 2024—may include duplicates)
‡ Spoke Eligible Patient Population (Average July–September 2024)

COMMUNITY HEALTH TEAM

The first year of the Blueprint Community Health Team Expansion Pilot has yielded significant success. At the time of writing, in the Burlington health service area, 18.84 FTEs have been hired through the Expansion Pilot, with plans to hire an additional 1.0 FTE to be fully staffed. The Expansion-funded positions are exclusively patient-facing, non-billing individuals who connect patients with community resources and/or provide brief intervention for Vermonters with substance use disorder or mental health concerns.

The CHT Expansion Pilot has provided the opportunity for strategic alignment between the Blueprint, University of Vermonth Health Network (UVMHN), OneCare Vermont, and other external partners, all of which have prioritized work around the social determinants of health (SDOH)/health related social needs (HRSN) and access to mental health and substance use disorder services. This focused attention and resources to address mental health, substance use disorder, and social determinants of health is a shared goal across these partners.

Through this pilot, Blueprint has been able to leverage UVMHN staff to support small, independent primary care practices struggling to hire their own staff. Blueprint/UVMHN staff have found creative solutions to solving mental health workforce shortages by partnering with four unique independent counselling organizations and the Designated Agency to embed mental health clinicians in primary care.

Community Health Centers, a Federally Qualified Health Center (FQHC), implemented a creative hiring solution; they created a hybrid Medical Assistant/Community Health Worker (CHW) position where 50% of their time is spent providing services to patients including: supporting screenings, referrals (in clinic and community), and providing follow-up (including case management). The CHW is an integral member of an interdisciplinary health care team and supports culturally and linguistically appropriate patient care. The CHW provides screening and navigation to services for mental health, substance use disorders, and SDOH. They are responsible for facilitating patient care including thorough and accurate documentation. They also assist with access to services with the goal of improving patient health, self-management, and advocacy.

> "The funding is the difference between being able to offer competent mental health support versus waiting almost a year for help when referring out. It's HUGE for us."
>
> —Naturopathic Clinic Manager in the Burlington HSA

ACHIEVEMENTS and ACCOMPLISHMENTS

Accountable Communities for Health

The Chittenden Accountable Community for Health (CACH) purchased and installed a confidential Youth Wellness Pod at Edmunds Elementary and Middle School, significantly improving access to mental health services. This initiative has reduced waitlists and increased the number of students receiving care. Compared to the same period last year, there has been a 154% increase in students receiving mental health services at school. By addressing mental health needs early, the Pod contributes to the All-Payer Model (APM) goal of reducing deaths by overdose and suicide. Additionally, the team has collected new access to care utilization and demographic data, which will enhance the initiative's scalability and quality improvement efforts.

My Healthy Vermont

In FY24, the My Healthy Vermont program navigated a successful merger of Burlington and Middlebury under one Provider Outreach Specialist. They established a partnership with the UVMMC Pain Clinic to create a direct referral pathway from specialty care to chronic pain workshops. Provider outreach specialists intend to replicate this approach to referrals with other specialty clinics in the coming year. Using Mail Chimp to track newsletter engagement has provided more data about what information providers and partners find most helpful. A new quarterly newsletter called the *Mindful Messenger* included information like a dot phrase for providers to use in Epic to refer patients directly to programming. We were successful in launching 12 workshops for the year, supporting 120 Vermonters working towards healthier lifestyles.

> "We have been able to provide in-house mental health supports with this funding to bridge the gap between acute need and finding a resource in the community. There have been many scenarios with patients who score high on PHQ and GAD during office visits with PCP and who have not been able to find counselors in the community. These patients have benefitted greatly from our in-house supports. We have seen patients whose mental health has been stabilized quickly who have started working through trauma and whose parents have been able to feel some relief that their child is being helped."
>
> —Pediatric Medicine Clinic Manager in the Burlington HSA

> "If this funding were to become sustainable, it would mean a lot more resources for patients, especially children with complex medical needs."
>
> —Blueprint Care Coordinator in the Burlington HSA

Key QI Work

Performance Improvement Team at UVMHN

UVMHN has established a Performance Improvement Team (PIT) to create standardization and efficiency related to quality improvement initiatives. As part of this work, UVMHN chose key performance improvement measures to align the High Value Care priorities with PCMH quality measures including depression screening, diabetes A1C control, Hypertension blood pressure control, and colorectal cancer screening.

The QI Facilitator supported additional quality improvement activities at UVMHN practices including:

- targeted outreach to patients with unprocessed kits to increase colorectal cancer screening
- centralization of transitions of care follow-up calls
- prioritization and outreach to patients with no upcoming appointment scheduled within the targeted time frame based on comprehensive risk stratification and other key data points including priority care gaps (which align with the quality measures outlined above), unaddressed conditions from prior year (indicated by high open Risk Adjustment Factor [RAF] values/uncoded HCC conditions).

Year 2 CHT Expansion Pilot Screening Implementation

- Quality teams identified opportunities to integrate mental health screening into more primary care visits and to improve connections to resources for patients with mental health needs. Several practices monitoring depression screening and appropriate follow-up plan saw improvement in the rate of screening in 2024. This worked was bolstered by a Center for Health and Learning project that supported practices developing safer pathways

to care for patients showing signs of suicidal ideation and by Quality Improvement Facilitator training focused on best practices for integrating behavioral health into primary care offered by the Care Transformation Collaborative of Rhode Island.

- Many quality teams focused on increasing measures of diversity (e.g. gender identify) collected by primary care practices as part of health equity initiatives. Facilitators, practice staff, and CHT members also participated in a variety of trainings focused on providing equitable care to all patients served.
- The Burlington community welcomed a new Community Health Center site (Essex) to the Blueprint in 2024 and a QI facilitator is supporting a naturopathic practice exploring the benefits of participation in the Vermont Blueprint for Health.
- We saw considerable collaboration between Blueprint facilitators and other quality-focused groups in our community. For example, facilitators participate in Chittenden Accountable Communities for Health (CACH) projects and coordinated improvement projects with the Health Departments' Immunization team. Quality teams identified gaps in screening for health-related social needs (HRSN), mental health, and substance use and are working to add questions to patient questionnaires, create new workflows, and improve connections with community-based partners.
- UVMHN adopted Blueprint and OneCare recommended ACH-HRSN tool (CMS 16). The new screening was built and launched in the EHR. Following the expansion of HRSN screenings (formerly SDOH), the UVMHN CHT noted a 50% increase in positive screenings and the number of referrals for follow up.

> "This is by far the most impactful support we have ever received as a practice and should become a model for the state in how to approach the mental health crisis in children."
>
> —Pediatric Provider in the Burlington HSA

> "When I first met "Claire," I wasn't sure how effective a short-term, brief intervention would be. At our third or fourth appointment, . . . I asked her to think back on what had worked before and what skills she could call upon today. She paused and said, 'You're giving me h....' I expected her to say "homework," but she said: 'Hope. You're giving me hope.'
>
> It was deeply satisfying to receive this unexpected positive feedback. The beauty of this integration with primary care is the ability to meet people where they are, where they feel safe, comfortable, and have a sense of familiarity. I'm so grateful that Claire was able to find a safe place to land."
>
> —CHT Expansion funded Mental Health Clinician in the Burlington HSA

FUTURE GOALS

Team-Based Care

There are many opportunities within our HSA for formal care coordination across teams and organizations, including: quarterly countywide All Spoke Meetings, Care Coordination in Chittenden County Meetings which are facilitated by UVMMC's Working to Reduce Admissions Program, and various meetings hosted by OneCare Vermont. Most care coordination happens through our staffs' knowledge of community resources and the work of the CHT/Medications for Opiod Use Disorder (MOUD)/Pregnancy Intention Initiative (PII) in our broader community, which allows for constant outreach and connection.

Chronic disease management

In collaboration with the Data Management Office, UVMHN has developed a suite of reporting tools to support quality initiatives in six key areas: Depression Screening and Follow Up, A1C Poor Control, Colorectal Cancer Screening, Hypertension Control, Annual Wellness Visits, and % RAF Closed. The Blueprint measures included in that list are A1C, Depression, and Hypertension. These tools display

performance data at the network, hospital, practice, and provider level, allowing us to pinpoint specific opportunities for performance improvement.

Reducing deaths by overdose/suicide

- Two practices in the Burlington HSA participated in the third round of the Zero Suicide Mini Grant. UVMHN formed an internal multidisciplinary workgroup to advance the goals of the grant. The workgroup recommended universal Columbia Suicide Severity Rating Scale (C-SSRS) screening at adult annual wellness visits. The pathway is in pilot phase at several clinics across the network for further review and implementation. The network developed a provider- and patient-facing UVMMC *Behavioral Health Resource* flyer.
- Our Spoke Partners continue to participate in the Burlington Mayor's Office Community Statistics meeting with the new mayor which addresses trends in overdose deaths and identifies strategies to improve access and outcomes for patients living with addiction.

Accessing primary care and specialty care

- The University of Vermont Medical Center, as part of the UVMHN, is committed to creating an exceptional experience for employees and patients. Improving access to care is one of the Network's goals for the year ahead along with increasing the value and affordability of care and delivering safe, effective, and equitable care.

> "I was connected to a [person who] needed transportation support, had a concern for domestic violence, and positive screens for multiple other health-related social needs. I was able to . . . reschedule the appointment, provide bus passes . . ., and connect [the patient] with WIC, STEPS, 3Squares, and other community supports. I was able to do this at the times the patient was ready for them and in the ways in which they were able to receive them. This, to me, is best practice, and our wrap-around care had the added benefits of preventing an Emergency Department visit, a potentially lengthy hospital admission, and increased hospital costs."
>
> —PII Social Worker

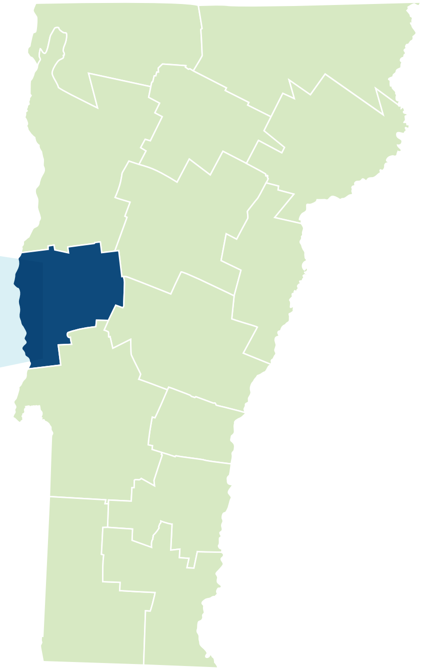
MIDDLEBURY HEALTH SERVICE AREA

Program Manager: Emmy Wollenburg

At a Glance

20,460	Health Service Area Total Population
15,509	Blueprint Practices Patient Attribution
5,064	Community Health Team Patient Count*
148	Spoke-Eligible Patient Population‡
5.56	Community Health Team Staff FTE
1.46	Spoke staff FTE
.5	Pregnancy Intention Initiative Staff FTE

* Community Health Team Patient Count (January–September, 2024—may include duplicates)
‡ Spoke Eligible Patient Population (Average July–September 2024)



COMMUNITY HEALTH TEAM

The first year of the Blueprint Community Health Team Expansion Pilot has yielded significant success. At the time of writing, in the Middlebury health service area, 3.9 FTEs have been hired through the Expansion Pilot, with plans to hire an additional 1.0 FTE to be fully staffed. The Expansion-funded positions are exclusively patient-facing, non-billing individuals who connect patients with community resources and/or provide brief intervention for Vermonters with substance use disorder or mental health concerns.

The CHT Expansion Pilot provided the opportunity for strategic alignment between the Blueprint, UVMHN, OneCare Vermont, and other external partners, all of which have prioritized work around the social determinants of health (SDOH)/health related social needs (HRSN) and access to mental health and substance use disorder services. This focused attention and resources to address mental health, substance use disorder, and social determinants of health is a shared goal across these partners.

> "Due to the Expansion Pilot, we changed our workflows regarding depression screening. We have also implemented a new wait list/referral process for our mental health clinician that is working very well."
>
> —-Practice Supervisor in the Middlebury Health Service Area

Through this pilot, Blueprint has been able to leverage UVMHN staff to support small, independent primary care practices struggling to hire their own staff. Blueprint/UVMHN staff have found creative solutions to solving mental health workforce shortages by partnering with the Vermont Center for Resiliency to embed mental health clinicians in two Middlebury independent primary care practices, with plans to expand mental health supports to an additional pediatric practice.

Clinicians are now working at Village Health and Natural Family Health in Middlebury, providing embedded mental health services to small, independent practices. This relationship has also be successful in larger practices, including Evergreen Family Medicine in Burlington.

ACHIEVEMENTS and ACCOMPLISHMENTS

Accountable Communities for Health

During the past year, the Addison County Community Health Action Team (CHAT) focused on housing as a key priority for the community. This has been reinforced by the recently completed Community Health Needs Assessment which identified housing, access to health care, and mental health/substance use disorder as the three priority areas for the Community Health Improvement Plan. CHAT will provide the infrastructure for the development and rollout of the CHIP going forward.

My Healthy Vermont

In FY24, the My Healthy Vermont program navigated a successful merger of Burlington and Middlebury under one Provider Outreach Specialist. They established a partnership with the UVMMC Pain Clinic to create a direct referral pathway from specialty care to chronic pain workshops. Provider outreach specialists intend to replicate this approach to referrals with other specialty clinics in the coming year. Using Mail Chimp to track newsletter engagement has provided more data about what information providers and partners find most helpful. A new quarterly newsletter called the *Mindful Messenger* included information like a dot phrase for providers to use in Epic to refer patients directly to programming. We were successful in launching 12 workshops for the year, supporting 120 Vermonters working towards healthier lifestyles.

Supporting Patient-Centered Medical Homes (PCMH) to meet NCQA standards

The Blueprint QI Facilitator supported all practices in the Middlebury health service area with PCMH renewals. For UVM Health Network (UVMHN) practices, there has been significant work to standardize NCQA criteria across the network to improve care quality, consistency, accreditation, patient experiences, efficiency, and support data-driven decisions. All four Porter Medical Center and the five independently owned practices maintained NCQA PCMH recognition this year.

In 2024, the Middlebury Blueprint Quality Improvement Facilitator transitioned from an independent contractor position to a UVM Health Network position, allowing for seamless integration and alignment of Blueprint quality improvement efforts with the UVMHN performance improvement strategy.

Pregnancy Intention Initiative (PII) social worker provides necessary support to patients

There was transition in the Blueprint PII social worker position in 2024, with a new staff member joining the team in September. Our new team member will continue to provide thorough biopsychosocial assessments that include evaluating mental health, safety, and social determinants of health. She offers short-term counseling and works collaboratively with internal and external colleagues to create multi-disciplinary teams of support for patients.

Year 2 CHT Expansion Pilot Screening Implementation

UVMHN adopted Blueprint- and OneCare-recommended ACH-HRSN tool (CMS 16). The new screening was built and launched in the electronic health record (EHR). Following the expansion of HRSN screenings (formerly Social Determinants of Health), the UVMHN CHT noted a 50% increase in positive screenings and the number of referrals for follow up. All independent primary care practices, except Middlebury Family Health which was tracking the data differently and already performing very well, saw an increase in their rates of screening for depression and followup.

Key QI Work

Performance Improvement Team at UVMHN

UVMHN has established a Performance Improvement Team (PIT) to create standardization and efficiency related to quality improvement initiatives. As part of this work, UVMHN chose key performance improvement measures to align the High Value Care priorities with PCMH quality measures including depression screening, diabetes A1C control, hypertension blood pressure control, and colorectal cancer screening.

The QI Facilitator supported additional quality improvement activities at UVMHN practices including:

- targeted outreach to patients with unprocessed FIT kits to increase colorectal cancer screening
- centralization of transitions of care follow-up calls
- prioritization and outreach to patients with no upcoming appointment scheduled within the targeted time frame based on comprehensive risk stratification and other key data points including priority care gaps (which align with the quality measures outlined above), unaddressed conditions from prior year (indicated by high open Risk Adjustment Factor [RAF] values/uncoded HCC conditions).

"We have recognized the importance of health-related social needs and have built a system to both identify the needs and provide a link to the appropriate services. Our Blueprint-funded community health workers are an essential component of this work and are the key to help patients connect to community resources—whether it be navigating insurance coverage, parenting resources, or other social services."

—-Provider in the Middlebury Health Service Area

FUTURE GOALS

Team-Based Care

- The Blueprint Program Manager and Agency for Human Services District Director have established a strong working relationship to support team-based care. They have partnered with Counseling Service of Adison County (CSAC) leaders to advance the work of the Resilient Communities Committee to create trauma transformed systems in Addison County. They hosted a World Café in November 2024 to bring leaders from social service organizations, healthcare, transportation, and beyond together to create trauma informed shared language. This work will continue to unfold in 2025 as the committee finds new opportunities to advance trauma-informed teaming in Addison County.

Chronic disease management

- In collaboration with the Data Management Office, UVMHN has developed a suite of reporting tools to support quality initiatives in six key areas: depression screening and followup, A1C poor control, colorectal cancer screening, hypertension control, annual wellness visits, and percent RAF closed. The Blueprint measures included in that list are A1C, depression, and hypertension. These tools display performance data at the network, hospital, practice, and provider level, allowing us to pinpoint specific opportunities for performance improvement.
- In 2025, all UVMHN practices will focus on improving diabetes A1C poor control and controlling high blood pressure by implementing evidence-based care pathways, enrolling patients in both My Healthy Vermont workshops as well as care management programs, and actively reaching out to patients with chronic disease related care gaps.

Reducing deaths by overdose/suicide

- UVMHN participated in the ZeroSuicide grant and formed a network workgroup. The workgroup recommended universal Columbia Suicide Severity Rating Scale (C-SSRS) screening at adult annual wellness visits. The pathway is in pilot phase at several clinics across the network for further review and implementation. The network developed a provider- and patient-facing *PMC Behavioral Health Resource* flyer.

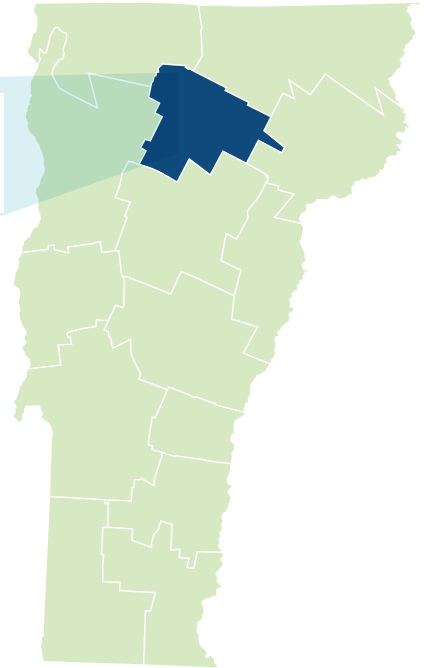
Accessing primary care and specialty care

- Porter Medical Center, as part of the UVMHN, is committed to creating an exceptional experience for employees and patients. Improving access to care is one of the Network's goals for the year ahead along with increasing the value and affordability of care and delivering safe, effective, and equitable care.

> "With the CHT Expansion Pilot, we did modify our SDOH screening to utilize the CMS-26 question screening which confirmed the need for access to a mental health counselor. We expect that will have a major impact on our practice and our patients."
>
> —-Practice Employee in the Middlebury Health Service Area

MORRISVILLE HEALTH SERVICE AREA

Program Manager: Hannah Ancel



At a Glance

20,535	Health Service Area Total Population
15,913	Blueprint Practices Patient Attribution
2,952	Community Health Team Patient Count*
258	Spoke-Eligible Patient Population‡
7.71	Community Health Team Staff FTE
5.3	Spoke staff FTE
.5	Pregnancy Intention Initiative Staff FTE

* Community Health Team Patient Count (January–September, 2024—may include duplicates)
‡ Spoke Eligible Patient Population (Average July–September 2024)

COMMUNITY HEALTH TEAM

This year we have worked to hire the 5.5 FTE Community Health Team (CHT) Expansion positions that our practices were eligible for. We began our hiring strategy by talking with each practice to assess their needs based on the patient population, current care team make up, and other resources available in that community. We knew that we wanted to focus on hiring more people with lived experience to reflect our communities, rather than solely traditional care coordination backgrounds and that we could train them as Community Health Workers (CHW). Also, knowing that the workforce is limited and that we did not want to recruit already licensed professionals for positions that do not need that credential, we reached out to the UVM master's in social work (MSW) program to cultivate internship placement within our team. The integration of the MSW Intern has been a great success in offering an opportunity for real world experience and providing direct support to our patients and team. The structure of the internship program has also taught us more about how we can train and support of all team members.

"Sometimes it starts with helping someone with one thing and they become comfortable enough to accept more. This happened with a patient who came in for help with insurance and by the end wanted to get connected to a therapist."

—-MSW Intern

"A patient with a new diabetes diagnosis met with me for diabetes education, we put on a sample continuous glucose monitor. During our session he expressed chest tightness and was triaged into Express Care to check his heart rate. Luckily the provider was able to rule out a cardiac issue. Their symptoms were, in fact, due to the anxiety they were feeling about their new diagnosis. Our brief intervention counselor was able to meet with them right then and, together with the education, they left feeling reassured. It is fortunate that could all be done in one visit instead of sending the patient to the ER."

—Diabetes Educator, CHT

ACHIEVEMENTS and ACCOMPLISHMENTS

While planning for the CHT Expansion, the partners of the Lamoille Health Collaborative had also been collaborating on a needs assessment and RFP for a close-loop referral tool which was identified by the CHT as important for more effectively getting patients the resources they need. We contracted with FindHelp, an online platform for finding resources, referring, and closing the loop across health and human service organizations. We are also able conduct health related social needs screening and create care plans within the platform. It is also proving

to be a helpful tool in onboarding the new CHT staff, as a huge part of the learning curve can be knowing what resources are in the community and how to refer. There have been over 600 unique users in our FindHelp site since January. Over 90 new local program profiles have been added to FindHelp. More and more organizations are receiving referrals through the tool and using it to streamline their intake processes.

> "Having the Capstone housing program intake form in FindHelp has made it much quicker to get people connected and know if they qualify for assistance."
>
> —Community Health Team Lead

To support the work of our expanding CHT, we also partnered with our local shelter, Lamoille Community House, and Lamoille County Mental Health to create the Recuperative Care Program, leveraging the Home and Community Based Services Grant through the state. This program addresses the barrier that CHT frequently run into with patients experiencing homelessness who cannot be successfully discharged from the hospital to homelessness or the traditional shelter.

This year we can report that on average our practices are screening 86% of patients for suicide risk. At times the nurses and providers expressed concern about asking the questions, however with the CHT Expansion staffing and trainings, there is much greater confidence. The patient feedback has been nothing but gratitude that we are asking the questions. It truly is having the impact of reducing the stigma of talking about mental health struggles. We are seeing this impact on the community wide data compared to previous years. We are hopeful that this will continue with this increased awareness and support in the community.

Our Medications for Opioid Use Disorder (MOUD) team is always working to improve services, support, and access. Starting this year the team has been hosting office hours at the recovery center to meet people in the community as well as implementing a food shelf at the Hardwick office. We have increased access to extended-release Buprenorphine injections with six of our eight sites providing access to the injections, a unique option and has been well received by patients. Since the Medicaid COVID exceptions have been lifted, a number of our patients are no longer income eligible for Medicaid. At this time about 40% of the patients being served by our MOUD team are not Medicaid enrolled and therefore not funded by the current Blueprint funding model for Spoke practices.

> "One quote that always sticks with me was from a patient that we were transferring to a different practice because it was more accessible for him to get to from home and work. When meeting with his new team for the first time he said, 'I wouldn't have stayed in treatment if it wasn't for my care coordinator.' We know that the medication is a motivator to remain in treatment, but the relationships are just as, if not more, impactful. Our teams often have the flexibility and time to really get to know the people we're working with and be there as their life grows and changes."
>
> – MOUD Clinician

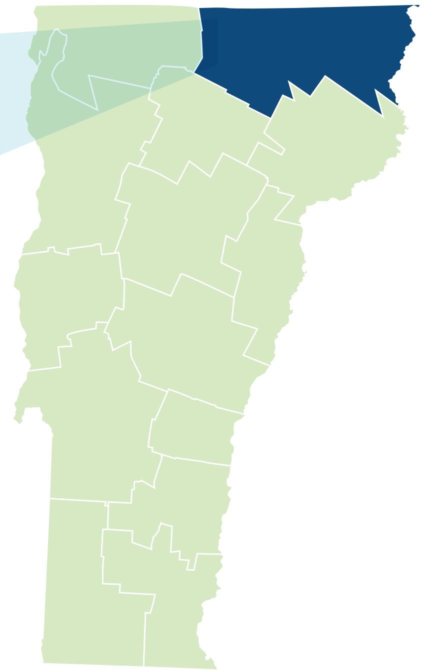
FUTURE GOALS

We look forward to building on our achievements to continue to improve team-based care across health and human services in our community. Growing the implementation of FindHelp as a shared tool will be key to this. The Lamoille Health Collaborative partners are also focused on housing solutions and are optimistic about the collective potential based on the success of the Recuperative Care Program launch.

> "This position gives the patient a safe place to explore concerns and get access to resources when they otherwise might not be able / willing to. Given that I'm not a doctor or a licensed therapist, I am less intimidating, and it is more casual than a structured office visit. We have flexibility with time to allow the patient to identify their needs, goals and make next steps with them."
>
> —Mental Health Care Coordinator, CHT Expansion

NEWPORT HEALTH SERVICE AREA

Program Manager: Meghan Fuller



At a Glance

22,169	Health Service Area Total Population
14,819	Blueprint Practices Patient Attribution
1,720	Community Health Team Patient Count*
117	Spoke-Eligible Patient Population‡
7.2	Community Health Team Staff FTE
3.9	Spoke staff FTE
.5	Pregnancy Intention Initiative Staff FTE

* Community Health Team Patient Count (January–September, 2024—may include duplicates)
‡ Spoke Eligible Patient Population (Average July–September 2024)

COMMUNITY HEALTH TEAM

The Community Health Team (CHT) provides quality, coordinated care to patients within the Newport Health Service Area (HSA). The CHT consists of Registered Nurses (RN), clinical care coordinators, dieticians, and community health workers (CHW) who are embedded in the Rural Health Clinics (RHC) in Newport and Barton as well as the Federally Qualified Health Center (FQHC) primary care practice in Island Pond. As part of the Blueprint CHT expansion program, we have added CHWs into our team. One care coordinator splits her time between being the Pregnancy Intention Initiative (PII) resource coordinator at the OBGYN office and being a care coordinator in the pediatrics office, allowing her follow moms and babies from one office to the other. The Newport HSA also continues to have a monthly meeting with partner agencies that addresses system's level gaps and barriers.

"The work our Community Health Team does is so important because so many people struggle to navigate the healthcare system, manage their chronic conditions, and need assistance with resources. Without our team, our most vulnerable patients would not get the care and help they need."

—-CHT Team Lead

ACHIEVEMENTS and ACCOMPLISHMENTS

A major focus for the CHT in the Newport HSA this past year continues to be the alignment of quality initiatives in our Accountable Care Organization (ACO) and Patient-Centered Medical Home (PCMH) work with population health efforts. Our diabetic work continues to capitalize on diabetic care changes made the previous year, and we're still seeing a lot of success with patients who enroll in the program. One of our care coordinators shared this success story: "I worked with someone who was a noncompliant diabetic for many years. She struggled for years. She could not get her knee replacement completed as her diabetes was poorly controlled. I started working with her earlier this year. . . . Convinced her to see endocrinology to help with her diabetes management. As of this month, her A1C is now at 5.8%, she is having her knee replaced next month. She was on four meds to treat her diabetes when we first started working together; and now, she only needs one. She is working on smoking cessation. She will be graduating from care coordination soon.

With the addition of CHWs to our team through the Expansion program, the Newport team implemented a more robust social determinants of health screening (SDOH) process in May of 2024. Key SDOH questions have been added to the annual demographics form given to all patients, both new and established. In May

2024, there were 1058 screens completed, and 574 were positive. The most frequent were: finances (329), food insecurity (118), and transportation (54). A future goal is to embed the full CMS Health-Related Social needs tool.

The completed forms are sent to our CHT where the positives are followed up on for intervention and further screening by our CHWs. We've also been able to coordinate this effort with our specialty practices who are utilizing the same demographics form. If they identify any positives, they send a referral to the Newport CHT for further screening. For patients seen at our specialty practices who receive their primary care in another HSA, this allows for a warm handoff from our CHT to the appropriate HSA's CHT.

FUTURE GOALS

Chronic disease management has always been a large part of what our CHT does and will continue to do. We continue to work closely with our providers to identify patients who would benefit from care coordination. The work done in previous years to improve our diabetes care will continue to be worked on to ensure we are providing evidence-base care to our patients. We continue to work closely with North Country Hospital's Emergency Department care coordinator to ensure patients with no primary care provider and/or significant social needs are identified and connected to our CHT. The Newport HSA is also participating in an initiative with the Agency of Human Services to advance Vermont Team-Based Care.

"A patient's cancer recently came back so had to start treatments, and he had lost his work and place to live so could not pay bills. We were able to get him connected to local community services for food and housing! This patient had been struggling every day, living in his vehicle while continuing treatments. He also got qualified for disability. He now lives in an apartment, cooks meals, and has a safe warm place to live."

—-CHT Expansion community health worker

"As a primary care physician practicing for 21+ years in the HSA with the highest measurable levels of county-level social determinants of health, it has been invaluable to have the resources of the CHT to meet our patients' needs. Having practiced before the implementation of Blueprint support and at times of full or less-than-full staffing, the CHT patients are served in ways that are not possible without that resource. We can provide resource lists, but the ability to meet the patient where they are and guide them to the community supports that they need creates a true care collaboration. For example, many patients are illiterate, and a list does no good. Mental health challenges may limit their ability to call or ask on their own. Many just don't know where to look. In a different vein, the space to provide health coaching has made a major difference in the measured outcomes for chronic disease management. Diabetics who are reached out to on a regular basis consistently improve their glucose control. Often you can see them backslide as they "graduate," as there is more need and not enough funding for ongoing wraparound support. Our hypertension management course was able to reduce blood pressure as much as our first-line medications but engaging patients in lifestyle modification. I and all my fellow physicians use this resource daily to the betterment of our patients, allowing increased and improved access and outcomes. "

—-Primary care provider

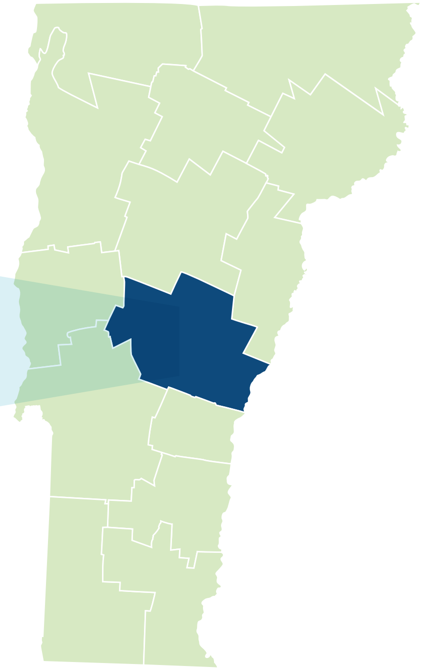
RANDOLPH HEALTH SERVICE AREA

Program Manager: Anthony Knox

At a Glance

10,922	Health Service Area Total Population
9,372	Blueprint Practices Patient Attribution
768	Community Health Team Patient Count*
51	Spoke-Eligible Patient Population‡
5.3	Community Health Team Staff FTE
1.2	Spoke staff FTE
.5	Pregnancy Intention Initiative Staff FTE

* Community Health Team Patient Count (January–September, 2024—may include duplicates)
‡ Spoke Eligible Patient Population (Average July–September 2024)



COMMUNITY HEALTH TEAM

The Randolph Health Service Area (HSA) continues to support patients to meet their social determinants of health (SDOH), mental health, chronic medical condition, and substance use disorder needs. We have individuals embedded into almost all locations within Gifford Health Care.

The Blueprint Team for the Randolph HSA is comprised of both clinical and non-clinical roles to support patients in the following roles:

Care Coordinators—There are four Care Coordinators that provide support for SDOH needs for all primary care patients throughout the Gifford Health Care system. The support helps patients meet their non-medical needs, which has shown to have a positive impact on their medical challenges.

Nurse Care Managers—There are two Nurse Care Managers that support patients' chronic medical conditions. The support that is provided helps a patient manage their chronic conditions and not seek emergency medical care or additional appointments with their primary care provider outside of the "normal" follow-up appointments.

Spoke Nurse—There is one Spoke Nurse who supports patients who are being treated for a substance use disorder. This support allows for patients to be more successful with their addiction treatment.

Licensed Clinical Social Worker—The social worker on the team provides support in two ways. They provide support within the Pregnancy Intention Initiative (PII), which helps patients within OB/GYN who need additional support leading up to their pregnancy due date. In addition, they provide support to the pediatric clinic at Gifford Health Care as part of the CHT Expansion Program.

Quality Improvement Facilitator—Our Quality Improvement Facilitator (QIF) has been a welcome addition to this team and continues to provide evaluation of our supports, in addition to ensuring we are meeting all required guidelines for the various state requirements. The QIF also works very closely with South Royalton Health Center to meet the same requirements that Gifford needs to meet.

We also provide pass-through funding to organizations within our HSA, South Royalton Health Center (an independent pediatric practice), and the Clara Martin Center. Funding for South Royalton Health Center is for their Care Coordinator and Care Manager and funding for the Clara Martin Center is for their Spoke Nurses.

> "CHT and Blueprint have been an incredible resource within our clinics to be able to work with our patients when they are struggling with both non-medical and chronic medical needs. It has been wonderful to have them embedded in our clinic as well to be able to do a warm handoff."
>
> —Gifford Primary Care Nurse

The Blueprint Team continues to support patients who are struggling with substance use disorders through the Hub & Spoke Program. Our Spoke Nurse works very closely with the Nurse Practitioner at Gifford Health Care that provides the clinical interventions for the patient. Gifford has also begun making more availability for same-day appointments to meet patient need and ensure access as soon as the patient is ready to accept service.

Our support related to the PII continues to be strong for expecting families. Our licensed clinical social worker works closely with the clinical staff in the OB/GYN clinic at Gifford to ensure the patients have the supports they need. These supports range from meeting SDOH needs to providing short-term therapy.

We continue to work with our self-management coordinator to ensure that we are aware of various educational programs for patients who may have a need or interest.

ACHIEVEMENTS and ACCOMPLISHMENTS

Gifford Health Care transitioned to a new electronic medical record (EMR) system in October 2023. Over the last year, there has been a lot of work to create a better mechanism to capture patients who could benefit from supports that are provided by the Blueprint Team. We have been able to create a "registry" for each location within Gifford Health Care to capture patients who screen positive for challenges related to a SDOH need. This has allowed us to capture and offer support to more patients. We continue to work with our EMR system and the primary care offices to ensure we are capturing all patients who need support.

In September of 2024, we re-started the monthly community collaboration meeting, now known as the Greatest Randolph Area Support Service (GRASS) meeting. The meeting is currently focusing on resource sharing amongst the social service agencies in the HSA, but as the meeting continues to grow, it will allow for sub-groups to meet and hopefully come up with additional resources for our community.

FUTURE GOALS

The Blueprint Team will continue to ensure that we are capturing patients who need our support. We continue to get referrals from providers, nurses and through "word of mouth," but that is not capturing all of the patients that need support. We will continue to improve processes and procedures within our EMR to identify the rest of the patients that also need support.

Another goal for the Randolph HSA is to hire additional staff for the Blueprint Expansion Pilot. We have struggled with finding quality candidates to fill these positions. The original plan was to hire additional clinical mental health social workers to support our HSA, but we need to re-assess and determine if that is what is needed for this area.

> "I am thankful for CHT to be able to support the patient in non-medical areas of concern and allow for me and my nursing staff to be able to just focus on their medical needs."
>
> —Gifford Primary Care Provider

RUTLAND HEALTH SERVICE AREA

Program Manager: Merideth Drude

At a Glance

46,104	Health Service Area Total Population
29,364	Blueprint Practices Patient Attribution
5,098	Community Health Team Patient Count*
353	Spoke-Eligible Patient Population‡
9.56	Community Health Team Staff FTE
6.93	Spoke staff FTE
1.0	Pregnancy Intention Initiative Staff FTE

* Community Health Team Patient Count (January–September, 2024—may include duplicates)
‡ Spoke Eligible Patient Population (Average July–September 2024)

COMMUNITY HEALTH TEAM

The staffing model for the Community Health Team (CHT) continues to utilize a spectrum of staffing to offer flexibility and creativity to meet the needs of our patients, practices, and community at large. Rutland Regional Medical Center employs the Core CHT staff, which includes RN case managers, social workers/mental health clinicians, along with a care coordinator focused on multi-visit patients of the Emergency Department and a case worker that supports direct navigation of social service programs. The Core CHT supports both pediatric and adult populations.

Additional Blueprint CHT funding is provided directly to the practices to support panel management for our independent practices: Associates in Primary Care, The Hogenkamps Family Practice, and Marble Valley Health Works.

The Federally Qualified Health Center (FQHC) for the Rutland Health Service Area, Community Health Centers of the Rutland Region, receives CHT pass-through funding to support chronic condition care management needs in their six primary care sites through their RN care manager positions.

The staffing for the Pregnancy Intention Initiative (PII) has been stable for years, with a Behavioral Health Clinician addressing positive responses to the Social Drivers of Health (SDOH) screenings through referrals as well as brief intervention and supportive counseling. In the last 12 months, Rutland Women's Health Care has completed over 1243 screenings, with a 50 % positive screening rate. This data demonstrates the value of this resource to patients.

> "As primary care becomes more and more challenging in these modern times, our practice relies more and more on the Blueprint to help us recognize and care for the patients most at need, manage chronic disease, and support our practice."
>
> —Primary Care Provider

EXPANSION PILOT

The staffing for those practices participating in the Expansion Pilot has been fully utilized. Community Health Centers was able to maximize on the funding available and generate a total of eight full-time positions to support their expansion of SDOH screenings. The initial phase for the six practices has been to roll out the screenings for all patients receiving Care Management services, along with those receiving Behavioral Health Services. The second phase of implementation is underway and provides screening for all patients within the Community Health Centers practices.

The Hogenkamps practice hired a full-time Family Support Specialist (FSS), whose primary role is to provide support to all patients who have a positive screen. The FSS is also able to provide navigation for other needed community resource and referrals, such as advance directives, long-term care planning, and childcare services.

The Expansion has offered an opportunity to create additional workflows/collaboration between those positions funded by the Expansion Pilot and the Core CHT. With vast and long-standing knowledge, skill, and experience, the Core CHT serves as a consultative resource for the Expansion-funded positions. This model allows for continuity of care and a more efficient prioritization and use for all Blueprint-funded positions.

SPOKE

Overall, the Spoke practices and staffing have remained stable. As expected, there has been some turnover of providers and staff; but the four Spoke practices within the Rutland Health Service Area continue to support over 350 unique patients within the Health Service Area (HSA). The Rutland Regional Emergency Department continues to collaboratively partner with the Hub & Spoke practices to meet the needs of the Rapid Access to Medication (RAM) policy. The group meets quarterly, and time is used to identify successes as well as opportunities to enhance this practice. In addition, the use of Peer Recovery Coaches through the Rutland Turning Point greatly assists with the ability to support the patient transition from the Emergency Department to the Spoke or HUB site with a person-centered focus.

> "The Family Support Services (FSS) position has provided patients with 1:1 emotional support, resources, and referrals for numerous issues including anxiety, depression, grief, food, housing, transportation, substance use, advance directives, community and caregiver resources, and more. The position has allowed practitioners the ability to focus on medical issues, knowing a referral to FSS will provide patients with the necessary resources to address their social needs. The position has also increased community collaboration."
>
> —Embedded Expansion position

ACHIEVEMENTS and ACCOMPLISHMENTS

One area of success for the Rutland CHT has been the use of the Pediatric Community Health Team. This staffing support employs three full-time positions, including a social worker, behavioral health clinician, and RN case manager. These three positions support an average of 916 unique pediatric patients per quarter. These roles support the most vulnerable of our population in our HSA. The needs of these patients require skill and knowledge not only in navigating the complex system of pediatric care, but also the ability to assist families, caregivers, and the like in the navigation and access to care. Often this work includes collaborating with other agencies such as schools and childcare programs as well as state agencies like Department of Children and Families and specialty programs like Child Development Clinics, as well as programs like Children's Integrated Services. Staff provide invaluable support and care coordination assistance that have real-time impact as well as avoid the potential need for costly long-term health care interventions due to chronic medical or social conditions.

Another area of accomplishment is the community wide collaboration existing across the HSA. Rutland Regional Medical Center, Community Health Centers of the Rutland Region, and the Community Care Network (Rutland Mental Health) are utilizing the same Social Drivers of Health (SDOH) screening tool (The Well Rx). Sharing the same screening tool helps to align data and streamline community wide intervention strategies which include collaborative partnerships with the Community Health Needs Assessment and the Rutland Accountable Community for Care, known as the Rutland Community Collaborative. The ability to compile data that uses the same screening tool poises the Rutland HSA to make informed decisions to assist with prioritization of goals and interventions.

Data gathering and reporting continues to be in the forefront of all initiatives. In the last year, efforts have been made to foster opportunities to broaden reporting capabilities across multiple care settings which use varied electronic medical records (EMR). Two of the newly created reports include ED Utilization and Urine Collection (identifying appropriateness of the collection process in the community care setting) to

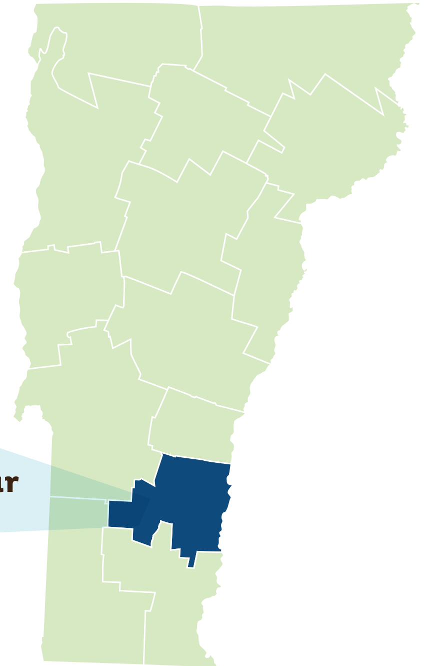
improve accuracy of results to improve treatment rates for Urinary Tract Infection. Reports which are underway include ED visits and associated chronic conditions, readmissions and timeliness of follow-up appointment times, and Hospice and Palliative care admissions rates along with length of stay.

FUTURE GOALS

The next year will continue to focus on the availability and use of data to support staffing and prioritization areas for the CHT. With a dramatic increase in staffing and engagement in the use of SDOH screening, the opportunity is now to better align and inform the interventions and designated resources for the Rutland HSA. Rutland has great depth and breadth of dedicated professionals to support our patients and community at large—now is the time to use data to better inform the way in which we perform this essential work.

SPRINGFIELD HEALTH SERVICE AREA

Program Manager: Tom Dougherty



At a Glance

21,443	Health Service Area Total Population
10,411	Blueprint Practices Patient Attribution
1,212	Community Health Team Patient Count*
132	Spoke-Eligible Patient Population‡
3.4	Community Health Team Staff FTE
3.3	Spoke staff FTE
0	Pregnancy Intention Initiative Staff FTE

* Community Health Team Patient Count (January–September, 2024—may include duplicates)
‡ Spoke Eligible Patient Population (Average July–September 2024)

COMMUNITY HEALTH TEAM

Our Community Health Team (CHT) has continued to evolve in response to community needs, Blueprint programs and initiatives, and available staffing and resources. In 2024 this included new CHT Expansion-funded Community Health Worker (CHW) positions. At present our CHT includes three CHWs, a registered dietician, an RN diabetes care and education specialist; a CHT Lead who is a Psyh/FM/DM NP, Spoke nurses, Medications for Opioid Use Disorder (MOUD) counselors, and staff dedicated to quality improvement and panel management. This team supports all practices in our area from a central location with dedicated time at each location, and collaborates closely with our local critical access hospital, Springfield Hospital, our local Designated Agency–Health Care Rehabilitation Services (HCRS)—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 MOUD programs, and school-based clinics. Care coordinators assist patients in addressing barriers to care, 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. Our CHT is participating in our area's Vermont Team-Based Care collaborative along with our local Designated Agency (HCRS), Area Agency of Aging, Vermont Chronic Care Initiative, Agency of Human Services, and housing service organization.

"I had a call from a woman with a lot going on, who was overwhelmed, not knowing what to do, and who had no transportation. So I went to her house, sat with her and asked, 'What do you need?' And she just looked at me and was like, 'You are the first person who's ever asked me that. Nobody ever asked me what I needed. They just tell me what they think I need.' I was able to help her sign up for disability, Supplemental Nutrition Assistance Program (SNAP), and other assistance, and have been touching base with her on a weekly basis. She's just so grateful for the CHT."

—CHT Expansion CHW

ACHIEVEMENTS and ACCOMPLISHMENTS

In 2024 we welcomed new staff, implemented the CHT Expansion and participated in the redesign of primary care teams in each of the Patient-Centered Medical Home (PCMH) practices in our area. The expansion implementation included new or revised screenings for health-related social needs (HRSN), substance and alcohol use, depression, suicidality, and pregnancy intention. The new workflows include improved followup facilitated by three new CHW positions, and we expect this will result in reduced waiting times to connect individuals to the services needed.

In concert with the Expansion, we incorporated our RN care coordinators, chronic care management and collaborative care nurses within the CHT department to enhance collaboration on our efforts to prevent and manage chronic conditions and team-based care.

Following the departure of long-time Medications for Opiod Use Disorder (MOUD) prescribers, our North Star Spoke program successfully engaged new primary care providers as prescribers and, in the process, added locations and expanded access to MOUD in our area. Support for patients on MOUD is now incorporated in all CHT clinical roles.

Our new CHWs provided an opportunity to refresh and strengthen collaboration with long-time community partners as part of their training and in their availability to increase community outreach activities. Our CHWs are key players in Springfield's Project Action initiative, which was developed in response to the Governor's Safety Summit and has led to improved engagement in care by some of our most vulnerable community members.

FUTURE GOALS

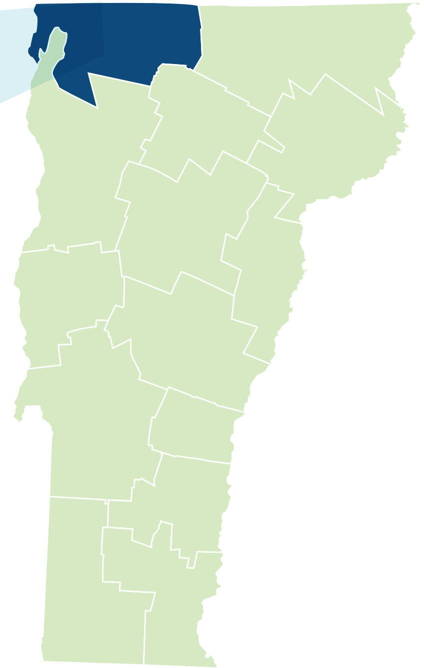
Looking to 2025, we will continue to refine and expand our new workflows, adding new screening for caregivers and pediatrics and will integrate panel management within our new primary care teams to facilitate utilization of care coordinators where they're needed most. With CHWs addressing health-related social needs and reaching out to people previously not engaged with primary care, we expect to see improvements in the prevention and management of chronic conditions in our community.

> "Working closely with people on behavior changes around diet is such a basic and important way we can help people be healthier, but it is very time consuming and couldn't be done without our CHT. I have so many patients who have benefited from the help of our dietician and diabetes educator. Putting resources in on the front end (prevention) saves people from long-term complications."
>
> —Primary Care Physician

> "Our outreach is having an impact—people are recognizing we're here for them, and they're engaging! We want people to know we're here; to know we want to help you. This is what we can do. Not just 'here's the resources,' but we're going to listen to you. We can help you determine what options you have and what resources there are that would help you get where you want to be. And so the impact that we've started to make is starting to show, which feels good."
>
> —CHT Expansion CHW

ST. ALBANS HEALTH SERVICE AREA

Program Manager: Jessica Frost



At a Glance

31,465	Health Service Area Total Population
19,390	Blueprint Practices Patient Attribution
5,158	Community Health Team Patient Count*
548	Spoke-Eligible Patient Population‡
11.35	Community Health Team Staff FTE
8.8	Spoke staff FTE
0	Pregnancy Intention Initiative Staff FTE

* Community Health Team Patient Count (January–September, 2024—may include duplicates)
‡ Spoke Eligible Patient Population (Average July–September 2024)

COMMUNITY HEALTH TEAM

The St. Albans HSA has a dedicated Community Health Team (CHT) who serves our neighbors, friends, and family members to achieve their health goals and solve health challenges. Our core CHT team is embedded in each of the 11 Patient-Centered Medical Homes (PCMH) in our region and is made up primarily of RN care coordinators with community health workers (CHW) and behavioral health clinicians. We partner with Northwestern Counseling and Support Services to provide expertise and supervision. We also employ embedded RN care coordinators and licensed alcohol and drug counselors for our Hub & Spoke Program in each of our primary care offices and specialty clinics, including the Howard Center, SaVida Health, and BAART.

"Care coordination impacts patients and families in different ways, the goals for each patient can and will look different. I meet them where they are and work to improve things from there. Often, we need to focus on small goals to start, then get the pleasure to celebrate accomplishments with them. Care coordination can impact a patient as a one-time thing or an ongoing relationship that will last years. It's special to see the difference you can make to someone and even more special to gain that patient's trust and develop a good relationship."

—RN Care Coordinator

ACHIEVEMENTS and ACCOMPLISHMENTS

In recent years, we expanded our monthly CHT meeting to include partners and improve collaboration and included a Resource Retreat for all to learn about the resources available in our region. This year's focus has been Social Determinants of Health (SDOH) screening and the process of connecting patients to community partners and resources. We focused on how to share screening information, improve referral communication, and ensure followup. We also incorporated the Team-Based Care Initiative into the CHT meeting, which complements our SDOH initiative.

We supported the PCMHs with a CDC cardiovascular disease grant, investigating workflows related to hypertension and addressing barriers to positive outcomes. We collaborated on the standardization of congestive heart failure education and mapped the flow from inpatient admission to followup appointments. We supported practices with their annual reporting requirements, conducted Blueprint Expansion Year 2 chart reviews to provide assessment of the PCMHs' implementation of screenings, and assisted in quality improvement (QI) for annual CAHPS surveys.

In partnership with our PCMHs, we supported NMC's Cancer Committee with QI around colorectal cancer screenings. We continue to work with our designated agency Northwestern Counseling and Support Services and Monarch Maples Pediatrics on suicide screening. Alongside multiple community partners we continue to address youth health, reduction of hospital readmissions, migrant health needs, housing needs, chronic disease, and participation and facilitation of the CAIRES Accountable Communities for Health. We helped coordinate a wound care task force initiative and partnered with the Vermont Department of Health's Immunization QI project. We maintain strong partnerships with MyHealthyVT and the Franklin-Grand Isle Tobacco Prevention Coalition, promoting prevention efforts.

FUTURE GOALS

We will build upon this year's success and expand the CHT's development opportunities. We will continue to incorporate education provided by the Blueprint central office and from local organizations in our CHT meetings. Continuation of SDOH screenings and improving the standard of care will remain a priority. Focus on streamlining referrals will continue, increasing efficiency in the process. We are exploring the model of Vermont Department of Health's CHARM model for high-risk expectant mothers to potentially replicate for our teams and partners. Collaboration to improve access to mental health and substance use disorder (SUD) screenings by creating agreements that allow shared assessments will allow us to work closer together and minimize duplicative questionnaires for patients. This will create ease of access, reduce triggering conversations, and support our population struggling with SUD.

"I have had the pleasure of working alongside the CHT team and community partners as the Blueprint QI Facilitator. Over the past year we have focused on a Social Determinants of Health initiative, and I could not be more impressed by the dedication and commitment this team has for the patients in our community and the effects of health-related social needs. This team has not only assisted their organizations with the implementation of screening but has been working towards improving the referral pathway to local resources to ensure patients are supported with the utmost respect and dignity. This is an engaged group of medical professionals that truly want to make a difference in their patients' lives. I am proud to work alongside them!"

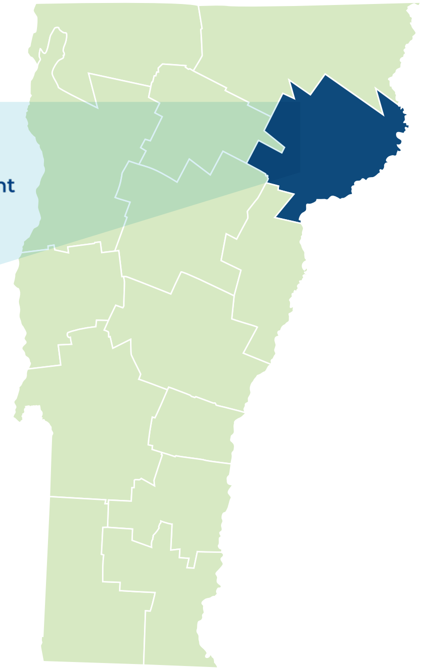
—QI Facilitator

ST. JOHNSBURY HEALTH SERVICE AREA

Program Manager: Diana Gibbs

At a Glance

20,819	Health Service Area Total Population
14,542	Blueprint Practices Patient Attribution
9,413	Community Health Team Patient Count*
96	Spoke-Eligible Patient Population‡
13.7	Community Health Team Staff FTE
2.58	Spoke staff FTE
.75	Pregnancy Intention Initiative Staff FTE



* Community Health Team Patient Count (January–September, 2024—may include duplicates)
‡ Spoke Eligible Patient Population (Average July–September 2024)

COMMUNITY HEALTH TEAM

The St. Johnsbury Health Service Area (HSA) Community Health Team (CHT) is essential to providing quality, coordinated care to patients. Our core CHT team staff are embedded within the six local primary care practices, including three Federally Qualified Health Centers (FQHC) operated by Northern Counties Health Care (NCHC) and three rural health clinics operated by Northeastern Vermont Regional Hospital (NVRH). Our CHT includes five behavioral health specialists (BHS), including a BHS supervisor, and six RN care coordinators. For the Pregnancy Intention Initiative (PII), NVRH's Women's Wellness Center practice has an embedded social worker. Supported by the Blueprint CHT Expansion, each practice has expanded community health worker (CHW) capacity, adding a total of 4.4 FTEs, which has increased access to support for social, mental health, and substance use needs and resources. Additional CHT staff include centralized CHWs located at NVRH Community Connections. Community Connections has served the community for over 20 years and supports individuals to find and connect to primary care and social and community services on a walk-in basis.

NVRH has been a leader and facilitator supporting a foundational culture of team-based care (TCB). The implementation and enhancement of this work occurs through feedback mechanisms working closely with other leaders and CHT staff. NVRH hosts the Integrated Care Team meeting designed to discuss the TBC approach and examine system-level gaps and barriers in order to identify collaborative solutions to reduce or remove barriers to care. Additionally, NVRH hosts a Core Team meeting that leverages the knowledge and experiences of frontline staff. NVRH has created parallel workflows between the two team meetings to ensure transparency and collective impact for systems-level challenges to enhance patient experience and outcomes.

"The Blueprint Expansion position has become a vital role at our practice and is essential to whole-person care. The CHT staff engage, support and guide patients in navigating the social determinants that prevent them from better health outcomes. The CHT staff provide the knowledge and resources that other clinical roles would find impossible to keep up with. This team takes time with the patients that others cannot provide. They meet patients where they are to identify goals and chip away at barriers. Patients would not consistently seek out this support if it was not provided in their medical home."

—Practice Operations Director

ACHIEVEMENTS and ACCOMPLISHMENTS

Working closely with primary care and community leaders, the St. Johnsbury HSA has continued to increase alignment across all health and human service providers. Over the last year, substantial effort has been dedicated to re-centering conversations including all aspects of the Blueprint. Internal systems were also examined to create transparency and ensure fidelity to the Blueprint model. Looking at the systems-level needs, the NVRH Community Health Improvement team—which includes the Interim Blueprint Program Manager, the Quality Improvement (QI) Facilitator, the CHT Lead, and the ACO Innovations Coordinator—have evolved a strategic work plan that further improves communication, tools, and collaboration, assuring quality patient care. High-level strategic priorities include increased provider engagement and understanding of TBC; creating consistency with workflows and pathways across inpatient and outpatient care settings; enhancing transitions of care and discharge planning; developing consumer education around TBC; assessing and identifying technology solutions for enhanced care coordination; and developing innovative CHW models aimed at addressing gaps across the system.

Building on prior year successes, the ACO Innovations Coordinator and the QI Facilitator collaborate to streamline quality improvement initiatives. QI Facilitation work has focused extensively on workflow modification to ensure data is captured for standard measure reporting, implementing preferred screening tools, and enhancing electronic medical record (EMR) capabilities for tracking, compliance, and reporting. Additionally, the QI Facilitator acquired the Hardwick Health Center, which ensures all five NHCH practices receive consistent support. Additionally, working with the Newport and Morrisville Program Managers, financial processes were streamlined for CHT and CHT Expansion reporting and payments.

New in 2024, NEK Prosper!—the Caledonia and Southern Essex accountable health community (AHC)—aligned to create one community health needs assessment (CHANA) process for the region. The benefits of this approach include the ability to leverage regional capacity and resources to produce one CHANA report and implementation approach that serve as the cornerstone document guiding and informing the work of NEK Prosper! and other NEK organizations, including the work performed by the NVRH Community Health Improvement team.

> "Everyone plays an important role to ensure that patients get the best quality care possible. I feel peer support workers are having a positive impact on patients by providing support that medical and behavioral health providers aren't able to provide, especially for new patients establishing care. Peer support workers are able to build a relationship by meeting with patients while they wait to see their provider."
>
> —Community Health Worker/Peer Support Worker (CHT Expansion Role)

FUTURE GOALS

With an eye on the Accountable Health Communities framework, the region is focused on community partnership across all population health and TBC initiatives and efforts. TBC efforts are tri-modal with a focus on the patient/consumer, system, and community. In the past few years, energy has focused on honing our approach to this work by integrating communication pathways to and from each level. The community continues to take a more cohesive and upstream approach to the challenges associated with chronic disease. The region has adapted approaches to a more preventative lens based on the Social Determinants of Health (SDOH) that coincide with whichever chronic disease that has presented.

Enhancing suicide prevention pathways will continue to be a significant focus. NVRH is in the third year of suicide prevention grant work within the Emergency Department (ED), which includes community partners, to bridge the gap between inpatient care and community care and ensuring that individuals are referred to primary care services for continuity of care. Coupled with suicide prevention pathway work done in the primary care setting, the goal is for a patient to experience consistent approaches and more informed care no matter where they enter the system.

In order to facilitate more seamless care coordination and transitions of care, community partners are working on developing a HIPAA-compliant agreement, called the Organized Health Care Arrangement (OHCA), which will allow for timely communication with and between providers. The

OCHA agreement, once in place, will reduce barriers to care coordination between the hospital, primary care providers, and providers within the local designated agency. Working with partners, NVRH will continue to focus on opportunities to reduce hospital and ED re-admissions, especially those related to medication reconciliation, which has been identified as a barrier to optimal health outcomes. Continued efforts will focus on developing a CHW/Medical Assistant pilot model aimed at reducing hospital and ED re-admissions. The position would bridge the gaps that occur between discharge planning and returning to the community where additional support may be needed. By leveraging TBC, the role would work to support and establish the individual within the community and provider network.

> "I value the CHT staff integrated in our practice as we can provide warm handoffs between providers and patients, have referrals made from SDOH screenings, and expect followups with the patients. I appreciate having CHT staff within our practice and it's made a positive impact on patient support and outcomes."
>
> —Practice Operations Director

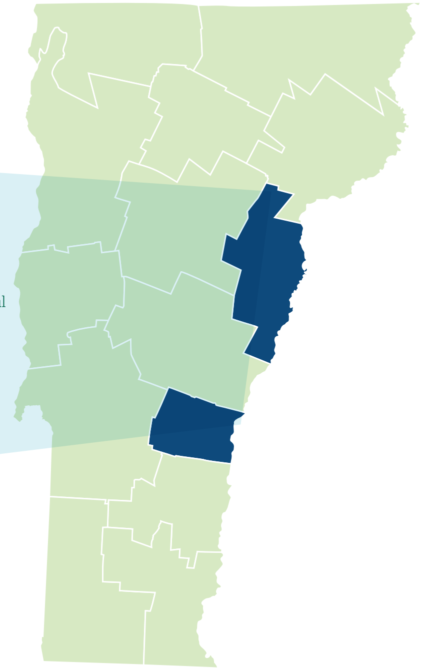
WINDSOR HEALTH SERVICE AREA

Program Manager: Erin Aiken

At a Glance

32,271	Health Service Area Total Population
12,662	Blueprint Practices Patient Attribution
2,887	Community Health Team Patient Count*
319	Spoke-Eligible Patient Population‡
9.23	Community Health Team Staff FTE
3.0	Spoke staff FTE
0	Pregnancy Intention Initiative Staff FTE

* Community Health Team Patient Count (January–September, 2024—may include duplicates)
‡ Spoke Eligible Patient Population (Average July–September 2024)



COMMUNITY HEALTH TEAM

The Windsor Health Service area is served by two community health teams (CHT): one based in the Mt. Ascutney region and the other in the northern region supported by Little Rivers Healthcare (LRHC) in Bradford. The Mt. Ascutney team, embedded in primary care within the Hospital, meets weekly for care coordination and team-based care across several organizations and many different service lines.

The Upper Valley UVP/LRHC team, embedded in various clinical practices spread across the area, meets monthly. These monthly meetings are dedicated to problem solving in challenging areas for all healthcare community partners.

Each primary care team meets with community partners on a regular basis (Mt. Ascutney Hospital and Health Center [MAHHC] meets weekly, and other teams meet monthly) to collaborate, problem-solve and share resources. Each team addresses clinical care, social and emotional care, behavioral health, and Social Determinants of Health (SDOH).

ACHIEVEMENTS and ACCOMPLISHMENTS

Little Rivers Health Care

The recent expansion of LRHC's CHT has bolstered our capacity to deliver integrated mental health and substance use care across multiple settings. This includes comprehensive screening, brief interventions, treatment options, and seamless service navigation and coordination. Our embedded care coordinators are now present in each of our four clinics, improving accessibility to confidential services. Additionally, new tablet-based screening tools are integrated with our electronic medical record system, enhancing data accuracy and patient engagement.

Our CHT has played a vital role in bridging gaps between patient needs and accessible care, serving as an essential resource for patients, staff, and partner organizations alike. Through these partnerships, the CHT has enhanced patient support pathways and strengthened our community connections, ensuring a more cohesive, responsive care experience across the HSA.

Upper Valley Pediatrics

In 2024, UVP has achieved several notable successes that positively impacted patients and community members. One significant highlight is the sustained collaboration with two CRN care coordinators, who have served throughout the year. Their consistent presence has enhanced access to services, allowing the team to better address patient needs.

Additionally, the quarterly Quality Improvement (QI) meetings held this year with an interdisciplinary team have played a vital role in supporting the sustainment of Patient-Centered Medical Home (PCMH) Recognition. The practice also celebrates continued mental health counseling via an on-site licensed clinical social worker.

White River Family Practice (WRFP)

WRFP continues to work on the CHT staffing changes we have faced as we only have two mental health counselors currently. We are able to provide telehealth appointments one day per week.

The implementation of the care planning module to support PCMH care management workflows and Certified Care Management (CCM) services is continuing to improve. Providers and the care coordinator have learned how to document and utilize these care plans. We anticipate these will improve over time as people are getting acclimated to new roles and learning processes.

We have successfully achieved our PCMH recognition under new practice management and have our multi-disciplinary practice team managing processes and evidence-based measure reporting to sustain recognition.

Mt. Ascutney Hospital and Health Center

Accomplishments this past year include the ongoing successful navigation of major changes in our community health structure as well as organizational leadership. Our HSA has taken significant steps toward enhancing cohesion and organizational efficiency. Through on-site visits, we have fostered stronger connections across teams, ensuring alignment with our goals.

The recent hiring of a new BP Program Manager has been pivotal in redefining and restructuring our organization, with a focus on improving communication and engagement at all levels. Additionally, our integration with primary care services has created a more seamless approach to patient care and strengthened collaboration, while our efforts to bolster community support have deepened trust and engagement with the populations that we serve. Together, these initiatives are driving meaningful progress in our mission to provide compassionate, exceptional, and integrated community health services.

FUTURE GOALS

The needs of the people in our communities have shifted dramatically throughout the year, particularly related to housing. We also need to continue to significantly address mental health (MH) and substance use disorder (SUD). Our future goals are to:

- Maximize utilization of CHT Expansion Pilot resources to address MH and SUD across the HSA
- LRHC is expanding our home visit program, supported by a dedicated team that includes a physician, nurse, social worker, and community health team members.
- Using new screening tools across the HSA that identify patient needs and connect them to CHT and clinical resources.
- Continue to work with the Camden Coalition for expanded collaboration in Team-Based Care across the HSA.

"I can't count the number of times I reached out for help on different matters, and each time, you were incredibly kind and understanding. You supported a woman navigating an unfamiliar caregiving role with compassion and patience. Your coordinator provided us with options and connected us to essential resources exactly when we needed them. Every member of your team has been extraordinary, offering support to our family at each step. Your commitment to expanding and strengthening your services speaks volumes about the dedication you bring to this work. Our family extends heartfelt gratitude to yours for everything you do."

—Patient

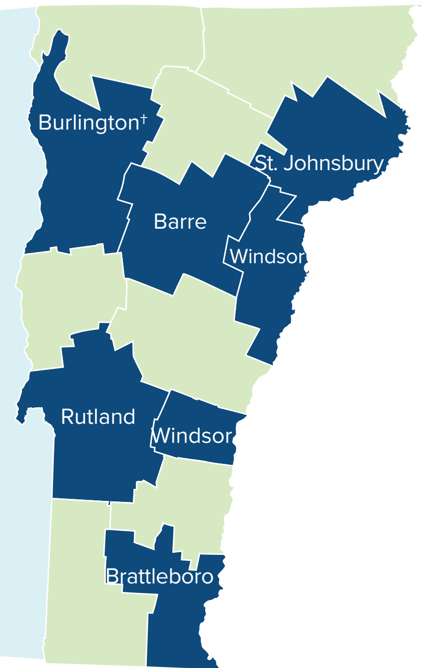
PPNNE HEALTH SERVICE AREA

Program Manager: Rey Francois

At a Glance

5995	Attributed Patients Statewide
1558	Patient Encounters - 11 months
2.8	Pregnancy Intention Initiative Staff FTE

† There are two Planned Parenthood sites in the Burlington HSA.



COMMUNITY HEALTH TEAM

We are pleased to announce that as of April 2024, Micah O'Connor has transitioned into the role of Integrated Behavioral Health Clinical Manager. Micah's progression from lead clinical support to overseeing clinical aspects of the program highlights his expertise and commitment to advancing patient care.

This spring we were excited to also on-board our newest integrated mental health professional, Jessa Morrish. Jessa comes to us with a robust background in supporting those who struggle with substance use, are survivors of domestic violence, or are in crisis. Through her work with patients and in the community, Jessa has been able to increase access to mental health, primary care, and community resources for many of our Burlington patients.

Currently, the Integrated Behavioral Health team includes one patient support counselor (PSC) splitting time between Brattleboro and White River Junction, another covering Williston and Barre via telehealth, and a full-time PSC based at the Burlington Health Center. We are actively recruiting for a position to serve the Rutland and St. Johnsbury areas to further expand accessibility.

While workforce shortages present challenges, we remain dedicated to filling these roles to enhance behavioral health services across Vermont, focusing on low-barrier access and trauma-informed care. These recent transitions demonstrate our unwavering commitment to delivering high-quality,

> "A patient recently accessed patient support counseling services who was identifying feeling safe but rapidly approaching a crisis point. This patient was engaging in substance use as a coping mechanism as well as reporting passive suicidal ideation. Through patient support counseling services, we were able to come up with a harm reduction plan, did safety planning around the suicidal ideation, provided support in reaching out to counseling referrals as well as support groups, and did psychoeducation around trauma until the patient was able to get connected to an ongoing therapist. It is so clear that the patient was this successful because she was able to immediately get support during the moment that she needed it most without having to wait for services, and that the immediate low-barrier support helped to avoid a crisis."
>
> —PPNNE Integrated Mental Health Provider

patient-centered services and meeting the evolving needs of the communities we serve. With a strengthened team and innovative leadership, Planned Parenthood of Northern New England (PPNNE) continues to make a meaningful impact in the lives of our patients

ACHIEVEMENTS and ACCOMPLISHMENTS

Despite the ongoing challenges posed by the COVID-19 pandemic and the overturning of *Roe v. Wade*, the PSCs have remained a vital resource for our community. They have worked tirelessly to provide support for patients navigating mental health concerns, addiction, and other behavioral health needs. Through innovative partnerships and collaborative efforts, they have connected patients to essential resources while reducing barriers to care.

In 2024, the PSCs achieved several notable milestones:

- Created partnerships with local oncology offices to better support patients with recent cancer diagnoses access care and needed supports.
- In 2024 our integrated mental health team met with over 150 patients during their scheduled medical appointments to provide in-the-moment support, emergently needed resources or warm hand-off to our PSC program.
- Our integrated mental health team have had the privilege of collaborating with Brattleboro Memorial Hospital in navigating barriers to creating an LGBTQ+ specialized primary care office to serve Brattleboro's growing LGBTQ+ population. Through their hard work, Maplewood Family Practice was able to hire a new primary care doctor with specialty in providing LGBTQ+ affirming primary care who is now hosting a "Pride Time" clinic. This new resource has already proven to be incredibly impactful for our Planned Parenthood patients seeking affirming and safe primary care.

We currently have three CHT staff trained as Certified Vermont Health Connect Assistors to aid our patients in enrolling in Qualified Health Plans (QHP), Medicaid for Children and Adults (MCA), Medicaid for the Aged, Blind, and Disabled (MABD), and the Immigrant Health Insurance Plan (IHIP). Assisters are supported by the Assiter Program team and are continually kept up-to-date on the changes in the health insurance market. Many of our patients come to us uninsured and feeling unable to meet their basic medical needs. Our staff are now able to support these patients in obtaining coverage not only for their care here at Planned Parenthood but in all areas of their lives.

In addition to these achievements, PSCs led a training for medical staff on recognizing trauma responses during pelvic exams or IUD insertions. This effort improved trauma-informed care and created safer, more supportive environments for patients. By addressing patient distress and providing grounding techniques, the team enhanced patient outcomes and increased accessibility to reproductive healthcare.

> "I am so grateful for our integrated mental health providers. I don't even know what to say or do when our patients are expressing fears and wanting answers. I can't give any reassurances, they'd all be false and that's not helpful. I am so grateful for all the folks providing therapy right now. I cannot imagine doing what they're doing, but I'm grateful for them doing it."
>
> —PPNNE Clinician in response to supporting patients during uncertain political climates

FUTURE GOALS

PPNNE's Integrated Behavioral Health (IBHSW) program continues to prioritize quality improvement and patient-centered care. Regular meetings with PSCs and the healthcare delivery team ensure collaboration and evaluation of progress. Our goals include expanding services to all health centers and telehealth platforms, strengthening partnerships with community organizations, and supporting as intermediary between long-term mental health care due to staffing shortages at designated agencies.

To mitigate these challenges, we offer bridge services, providing short-term, high-quality support until patients can access long-term care. These services address needs such as non-crisis suicidal ideation, life stressors, and distress tolerance skills. Visits are tailored to individual needs and range from weekly to monthly for up to six sessions. While not a substitute for long-term trauma care, these services enhance continuity of care and empower patients during critical moments.

As we move forward, we aim to further integrate behavioral health clinicians into all our health centers and expand telehealth offerings. These initiatives will continue to strengthen our commitment to accessible, trauma-informed care and ensure that every patient receives the support they need.

A patient seeking STI testing after a sexual assault expressed distress during their appointment. The PSC supported them in accessing trauma-focused outpatient care and provided short-term counseling. The patient later shared, "[The provider] truly supported me and gave me hope during the worst time of my life."

"I am new to the area and don't know where to start when it comes to getting connected to resources. Everyone I know told me to come here and talk to you. They said that you are really helpful in getting people set up with insurance and connected to medical and mental health services."

—Patient accessing services with our integrated mental health provider. They were able to get enrolled in insurance and started with a new primary care provider and therapist.

VI. APPENDIX: EVALUATION MEASURE RESULTS

The charts on the following pages display various healthcare quality measures reported in the Vermont Health Care Uniform Reporting and Evaluation System (VHCURES), Vermont's all payer claims database. These measures are provided as an overview of health utilization trends in Vermont.

Specifications for measures may have changed from previous Annual Reports. Because of this, the following charts are not intended to be compared to charts from previous Annual Reports.

If a measure result shows considerable variance or is not trending in the direction anticipated, the Blueprint mobilizes field staff and local quality improvement facilitators who have established relationships with local providers. They work together to identify the underlying causes of the decline and implement interventions to achieve the desired outcomes.

The charts found in the appendix are listed below in order of appearance.

CHART

1. **Population N**
   Total VHCURES Population
2. **Expenditures Total Per Member Per Year**
   Total VHCURES Population
3. **Special Medicaid Services Expenditures Per Member Per Year**
   Total VHCURES Population
4. **Developmental Screening in First Three Years of Life**
   Blueprint PCMH Primary Care Attributed Population
5. **Child and Adolescent Well-Care Visits 12–17**
   Blueprint PCMH Primary Care Attributed Population
6. **Hypertension with BP in Control**
   Blueprint PCMH Primary Care Attributed Population
7. **Diabetes HbA1c Not in Control**
   Blueprint PCMH Primary Care Attributed Population
8. **Asthma Medication Ratio (AMR) of Controller Meds to Total Asthma Meds of 0.50 or Greater**
   Total VHCURES Population
9. **COPD & Asthma Admissions, 40y+**
   Total VHCURES Population
10. **Heart Failure Admissions**
    Total VHCURES Population
11. **Cervical Cancer Screening**
    Total VHCURES Population
12. **Chlamydia Screening in Women 16–24**
    Total VHCURES Population
13. **Developmental Screening in First Three Years of Life**
    Total VHCURES Population
14. **Child and Adolescent Well-Care Visits 3–21**
    Total VHCURES Population
15. **Child Well-Care Visits 3–11**
    Total VHCURES Population
16. **Child and Adolescent Well-Care Visits 12–17**
    Total VHCURES Population
17. **Child and Adolescent Well-Care Visits 18–21**
    Total VHCURES Population
18. **Medical Specialist Encounters /1000 Member Years**
    Total VHCURES Population
19. **Primary Care Encounters /1000 Member Years**
    Total VHCURES Population
20. **Surgical Specialist Encounters /1000 Member Years**
    Total VHCURES Population
21. **Outpatient ED Visits /1000 Member Years**
    Total VHCURES Population
22. **Inpatient Discharges /1000 Member Years**
    Total VHCURES Population
23. **Outpatient Potential Avoidable ED Visits /1000 Member Years**
    Total VHCURES Population
24. **PQI92 Chronic Composite ACSC IP Discharges /1000 Member Years**
    Total VHCURES Population

HEALTH CARE EXPENDITURES

TOTAL VHCURES (EXCLUDING SELF-INSURED) POPULATION

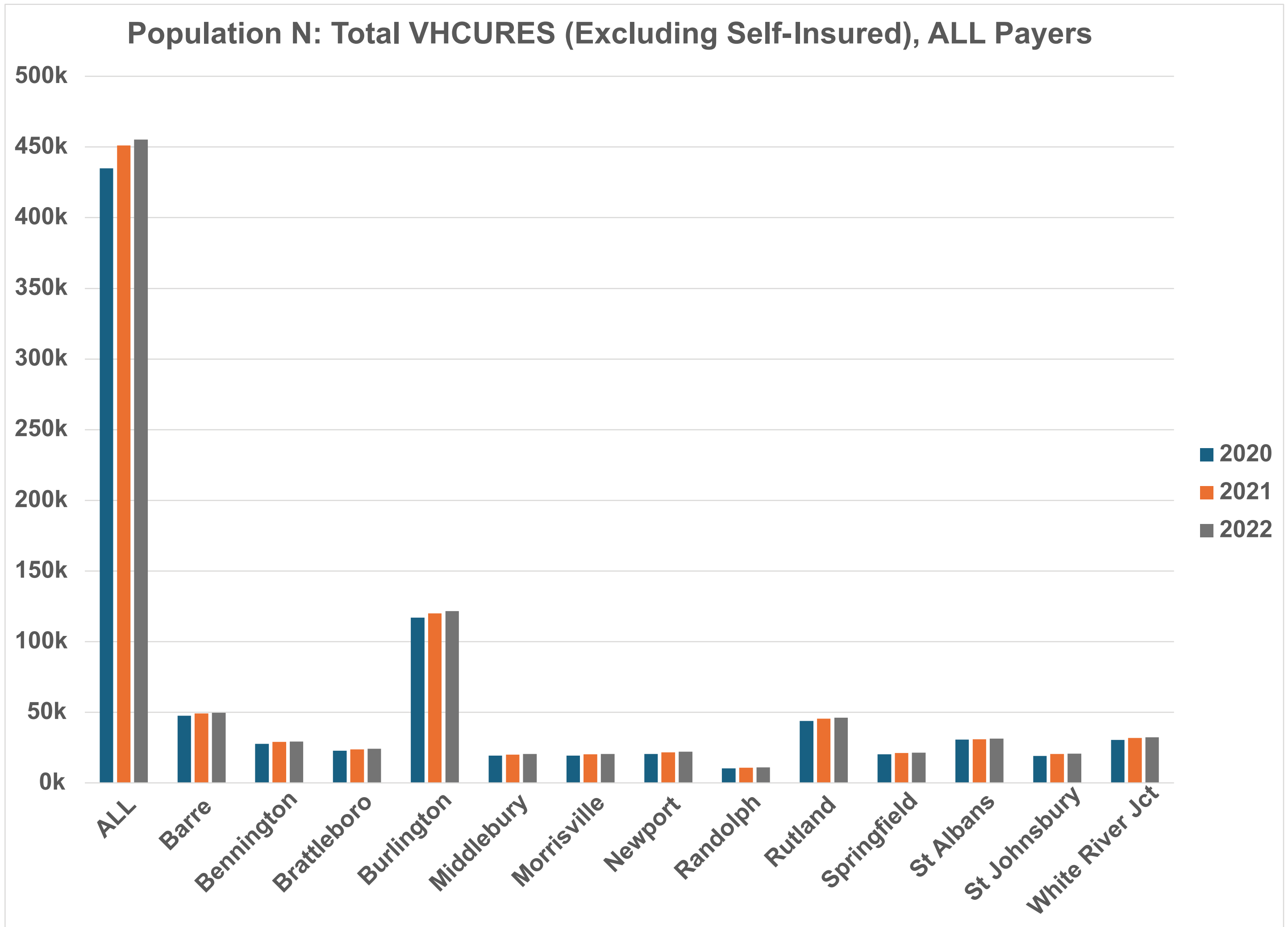


Chart 1 shows the total count of members in VHCURES in the measurement year with eligibility coverage by Hospital Service Area.

HEALTH CARE EXPENDITURES

TOTAL VHCURES (EXCLUDING SELF-INSURED) POPULATION

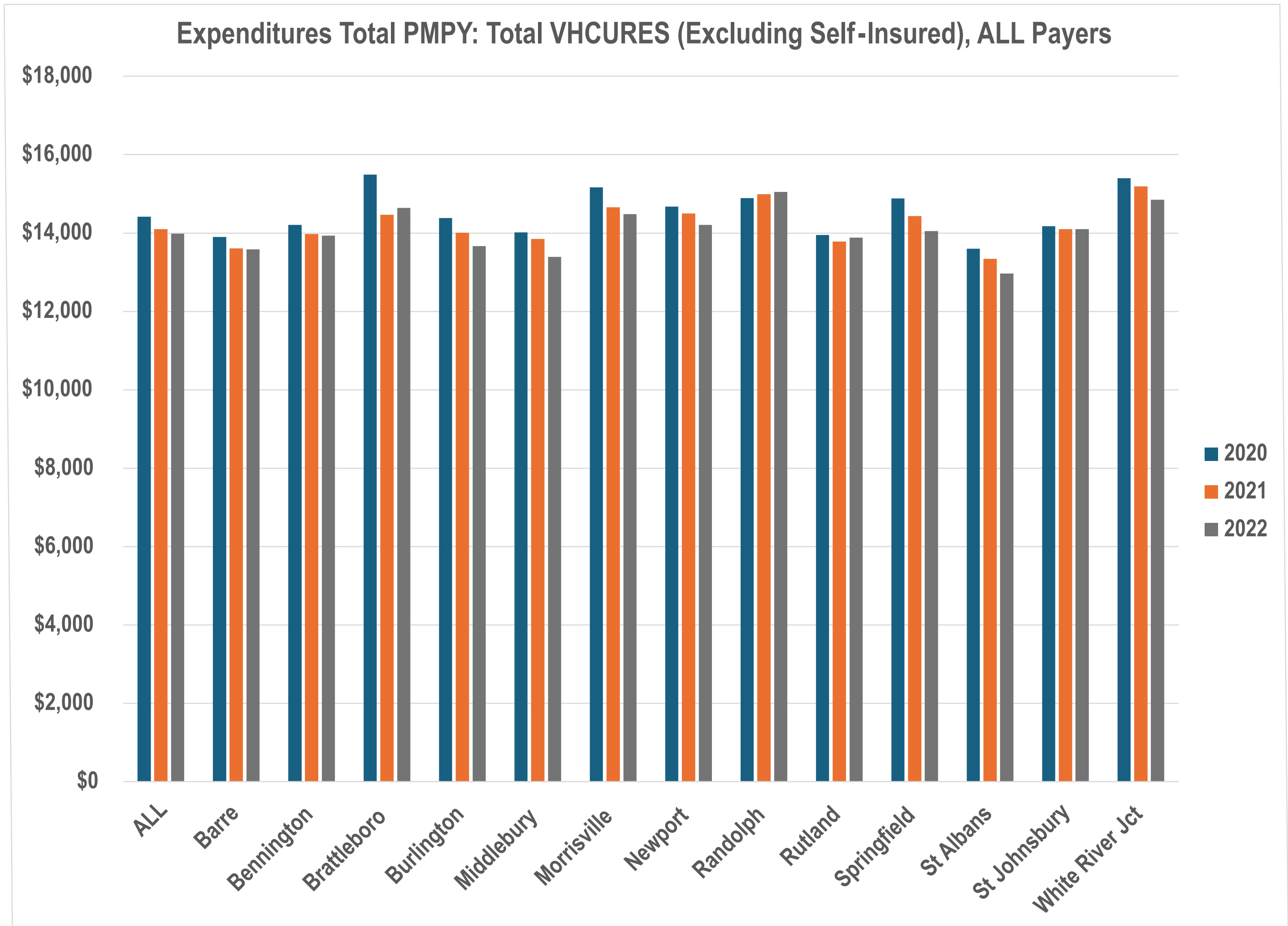


Chart 2 displays the total expenditures per member per year, reported as an inflation-adjusted and risk-adjusted per member per year (PMPY) rate by Hospital Service Area. In practical terms, this chart shows how much the total claims amount is per person per year in Vermont. Please note that the amounts displayed are not necessarily the amount paid by any individual Vermonter.

HEALTH CARE EXPENDITURES

MEDICAID-PRIMARY POPULATION

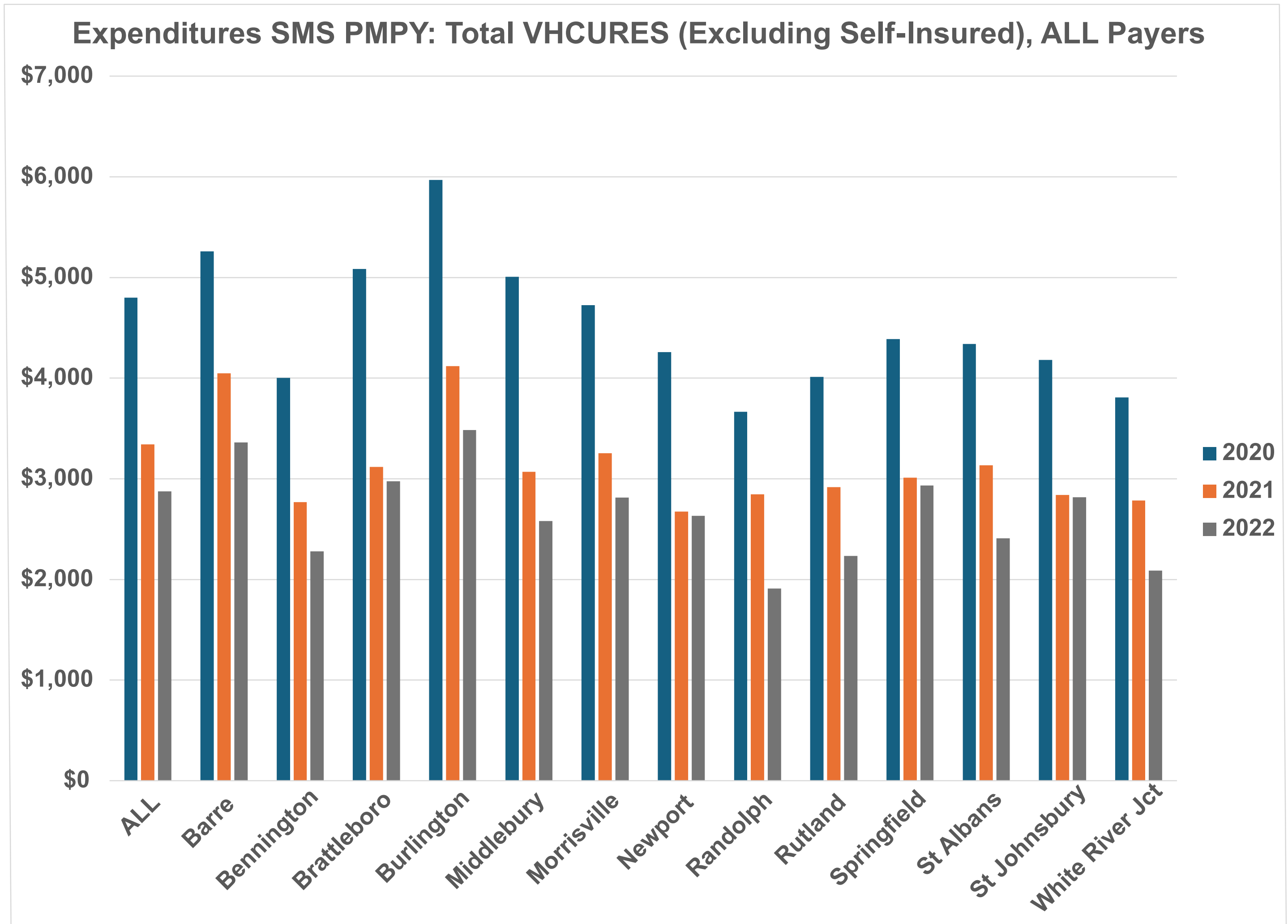


Chart 3 displays the total expenditures for Special Medicaid Services (SMS) reported as an inflation-adjusted and risk-adjusted per member per year (PMPY) rate by Hospital Service Area. Because Medicaid rates are not inflation adjusted annually, this measure will typically trend down.

HEALTH CARE QUALITY MEASURES

PCMH PRIMARY-CARE ATTRIBUTED POPULATION

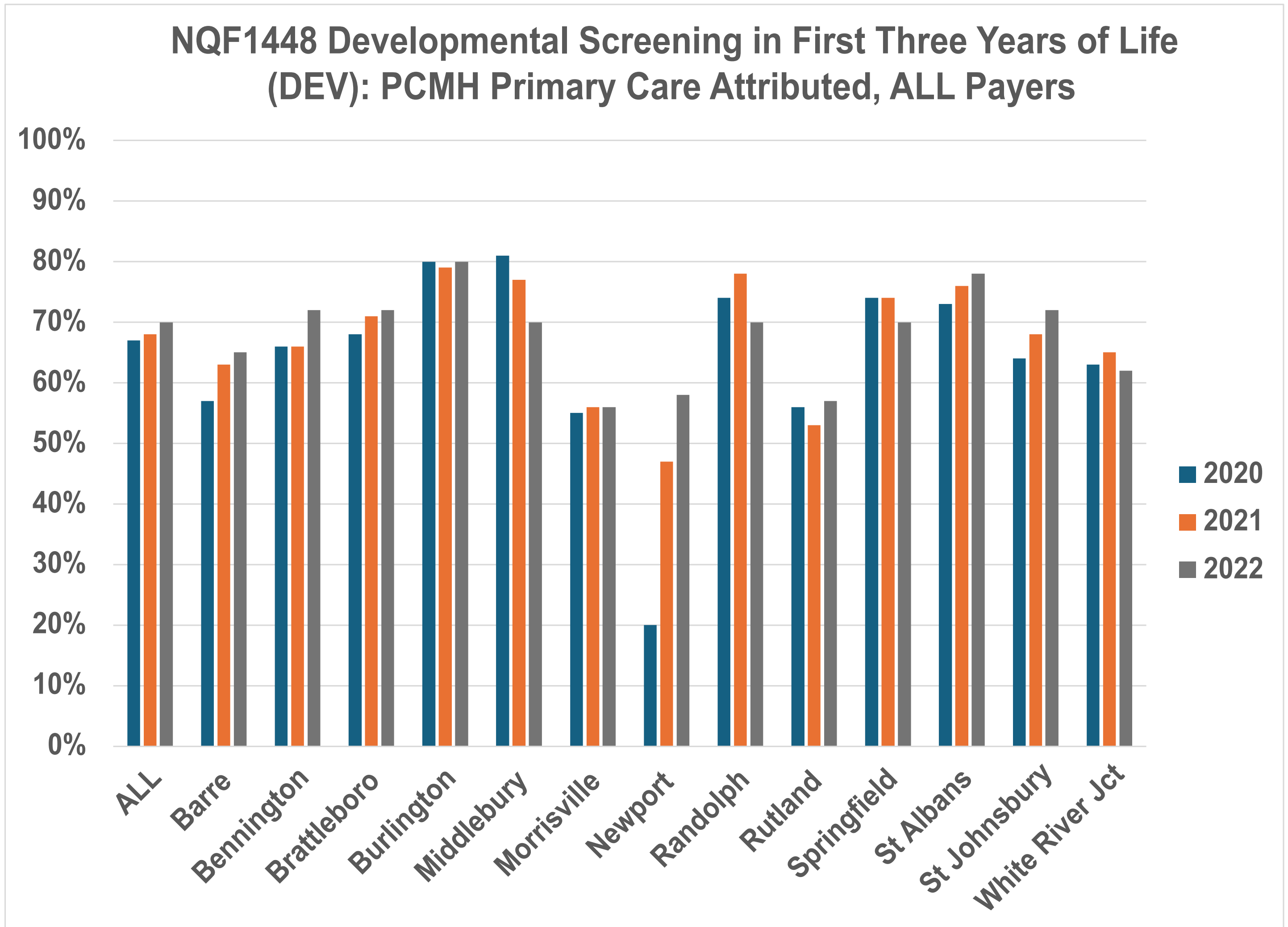


Chart 4 displays the percentage of Blueprint PCMH-attributed children aged 3 or less, who were screened for risk of developmental, behavioral, and social delays by the age of three by Hospital Service Area.

HEALTH CARE QUALITY MEASURES

PCMH PRIMARY-CARE ATTRIBUTED POPULATION

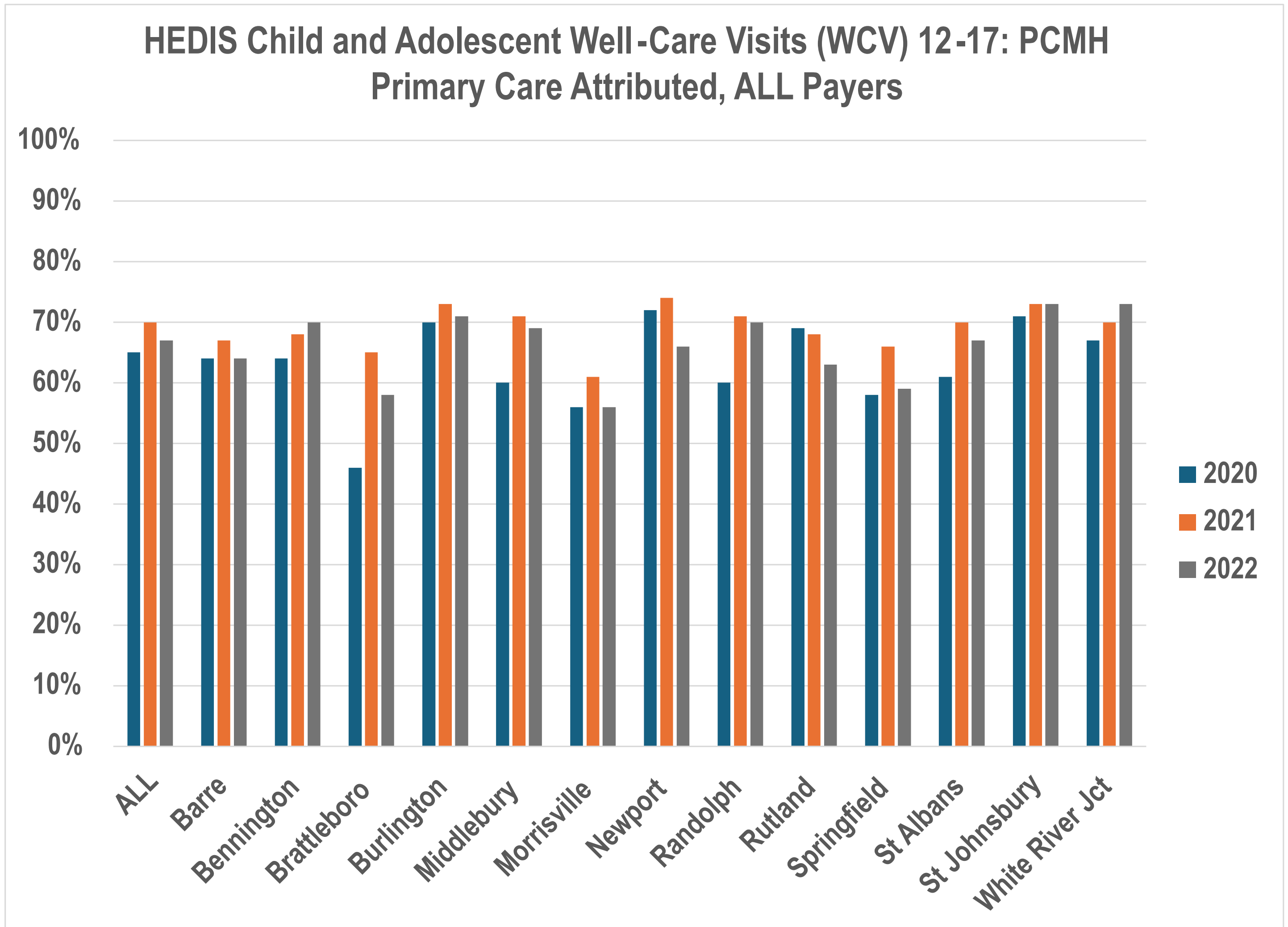


Chart 5 displays the percentage of Blueprint PCMH-attributed adolescents 12–17 years old who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year by Hospital Service Area.

HEALTH CARE QUALITY MEASURES

PCMH PRIMARY-CARE ATTRIBUTED POPULATION

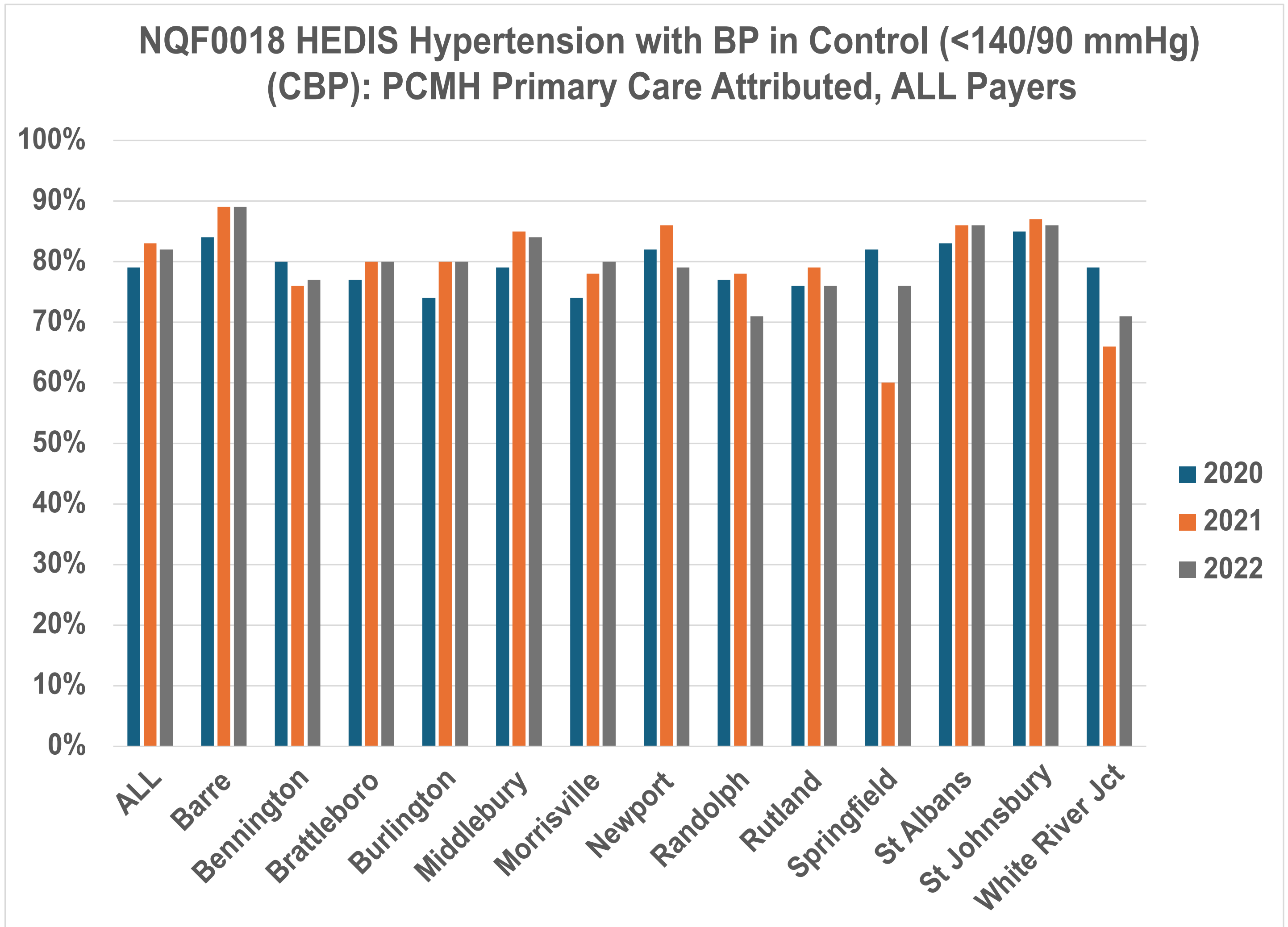


Chart 6 displays rates of Blueprint PCMH-attributed patients with hypertension who have blood pressure less than 140/90 mmHg by Hospital Service Area.

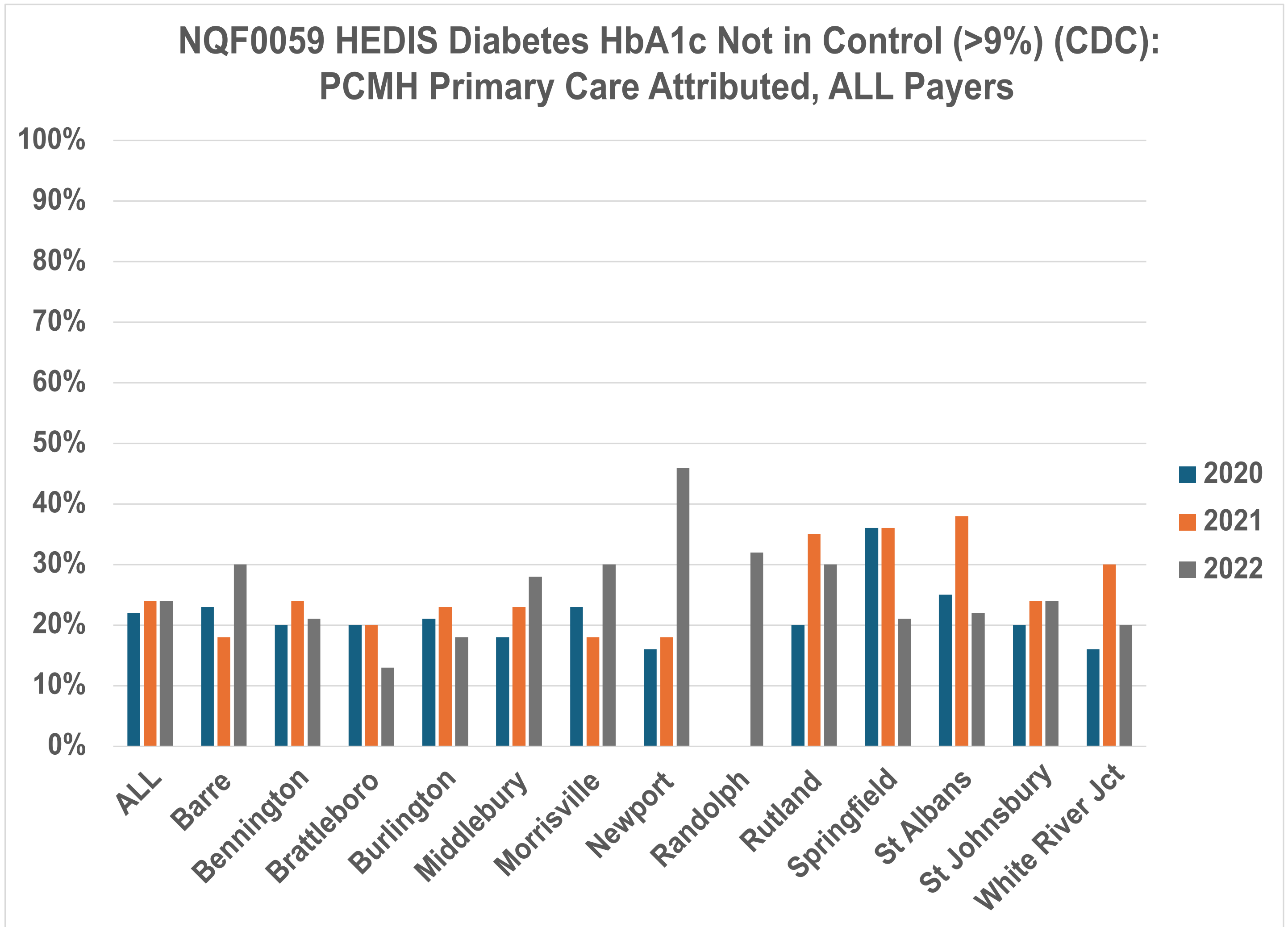


Chart 7 displays the rates of Blueprint PCMH-attributed patients whose diabetes HbA1c percentage is higher than 9% by Hospital Service Area. For this measure, lower rates are better. Data for Randolph in 2020 and 2021 is removed from this chart because the patient population for this measure is fewer than 11.

OTHER CHRONIC CONDITIONS

TOTAL VHCURES (EXCLUDING SELF-INSURED) POPULATION

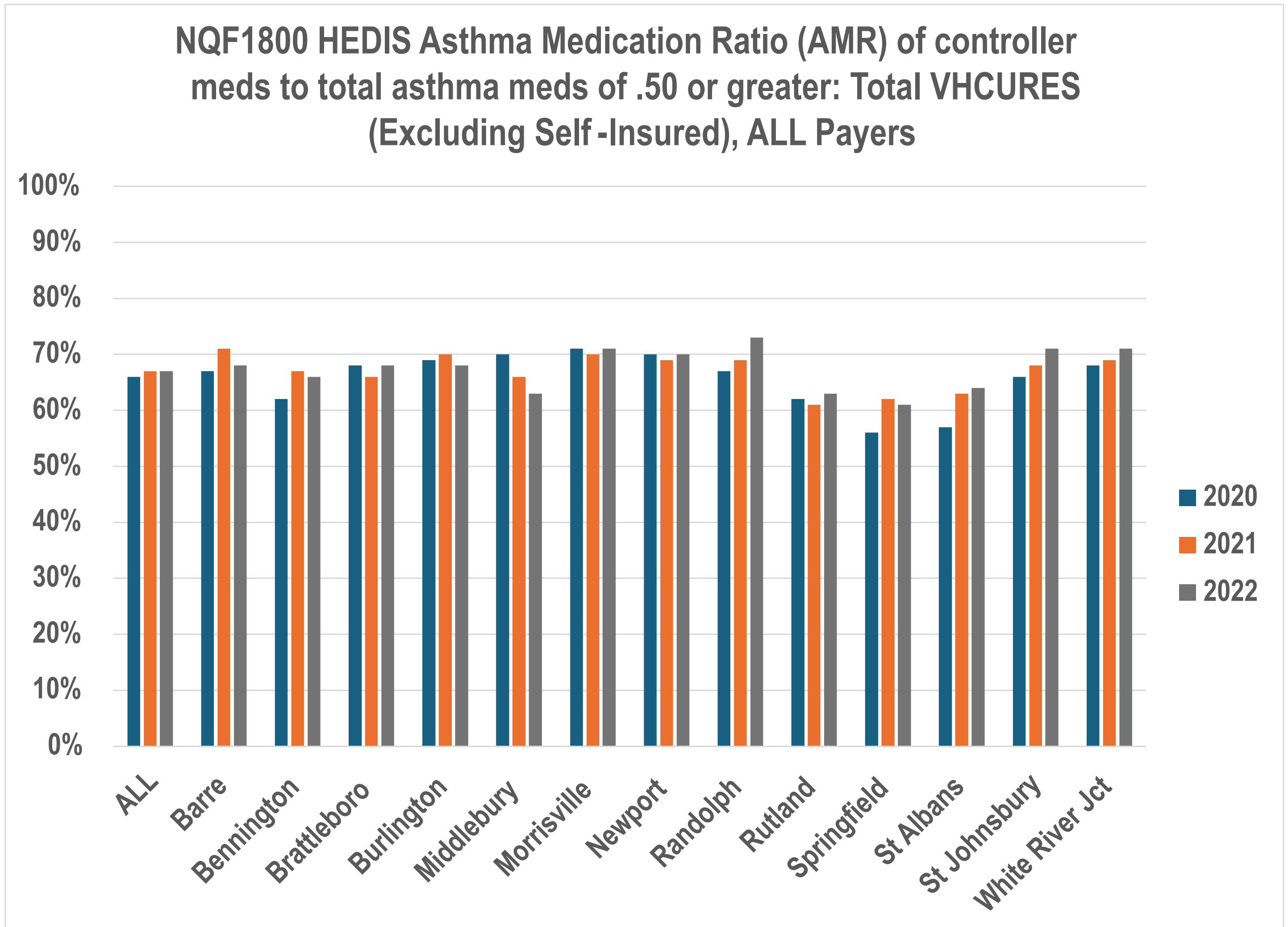


Chart 8 displays the percentage of the VHCURES population 5–64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year by Hospital Service Area.

OTHER CHRONIC CONDITIONS

TOTAL VHCURES (EXCLUDING SELF-INSURED) POPULATION

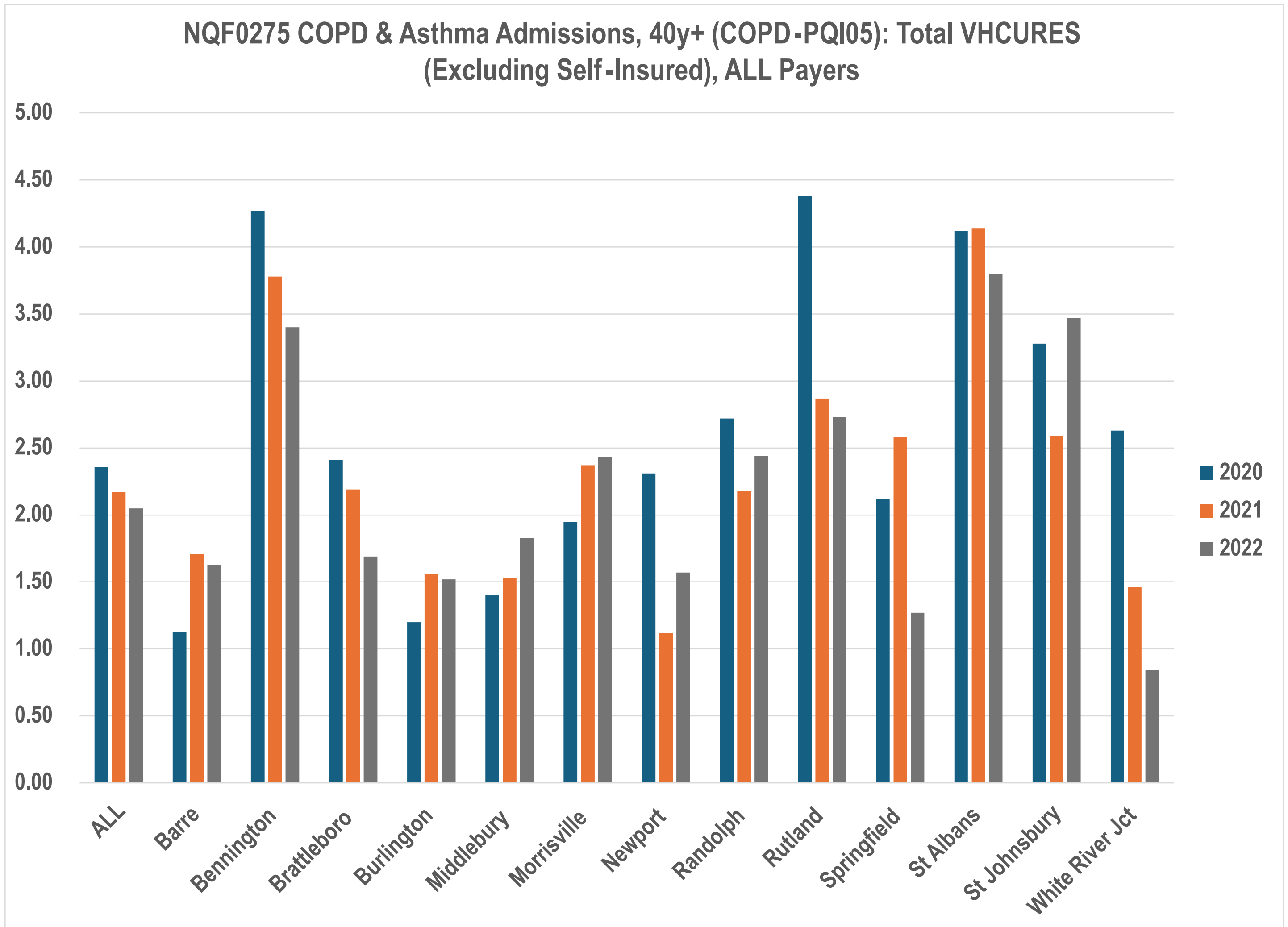


Chart 9 displays hospitalizations with a principal diagnosis of chronic obstructive pulmonary disease (COPD) or asthma per 100,000 people ages 40 years and older in the VHCURES population by Hospital Service Area. Excludes hospitalizations with cystic fibrosis and anomalies of the respiratory system, obstetric hospitalizations, and transfers from other institutions.

OTHER CHRONIC CONDITIONS

TOTAL VHCURES (EXCLUDING SELF-INSURED) POPULATION

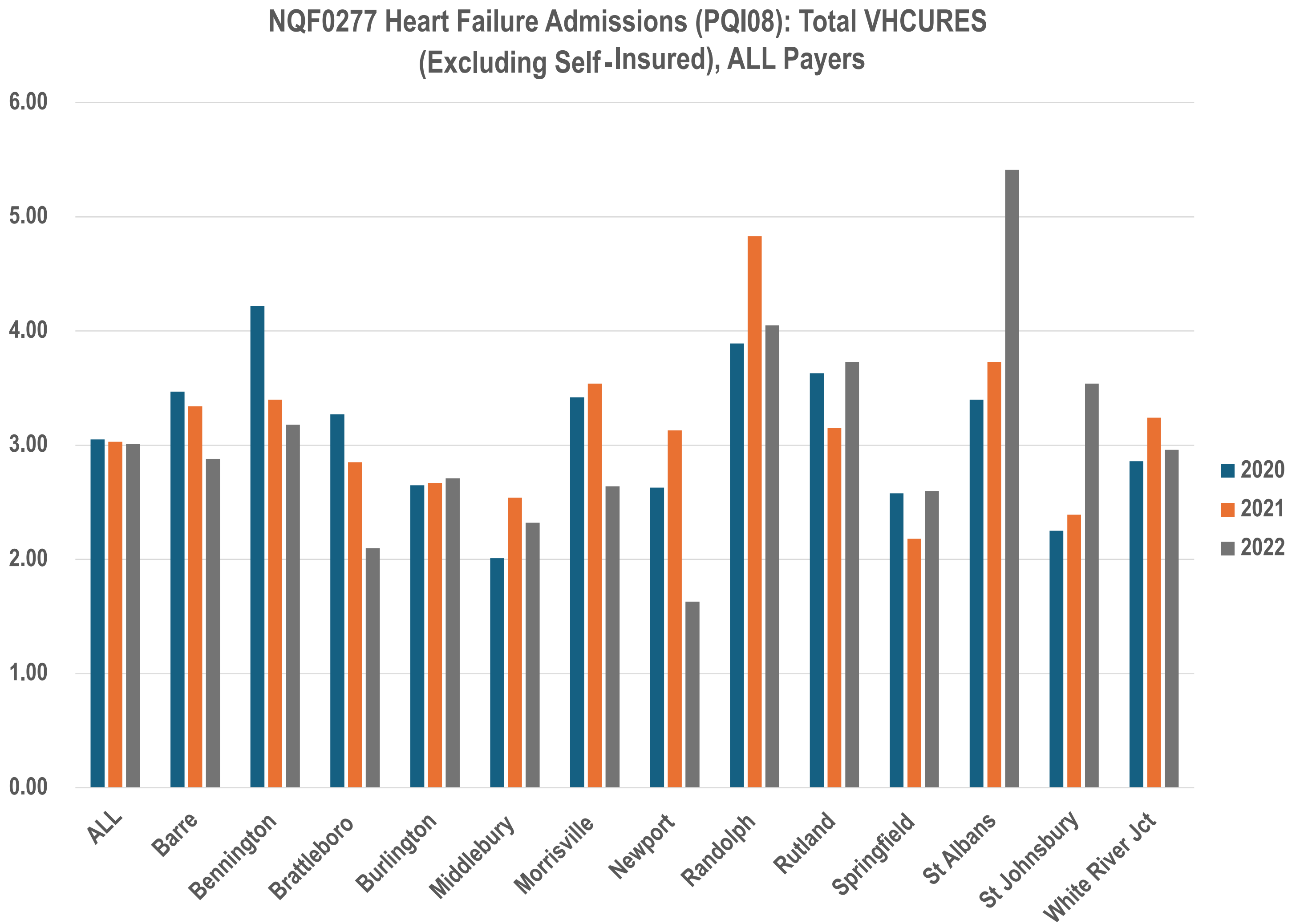


Chart 10 displays hospitalizations in the VHCURES population with a principal diagnosis of heart failure per 100,000 population, ages 18 years and older by Hospital Service Area. Excludes hospitalizations with cardiac procedure, obstetric hospitalizations, and transfers from other institutions.

WOMEN'S PREVENTATIVE HEALTH CARE MEASURES

TOTAL VHCURES (EXCLUDING SELF-INSURED) POPULATION

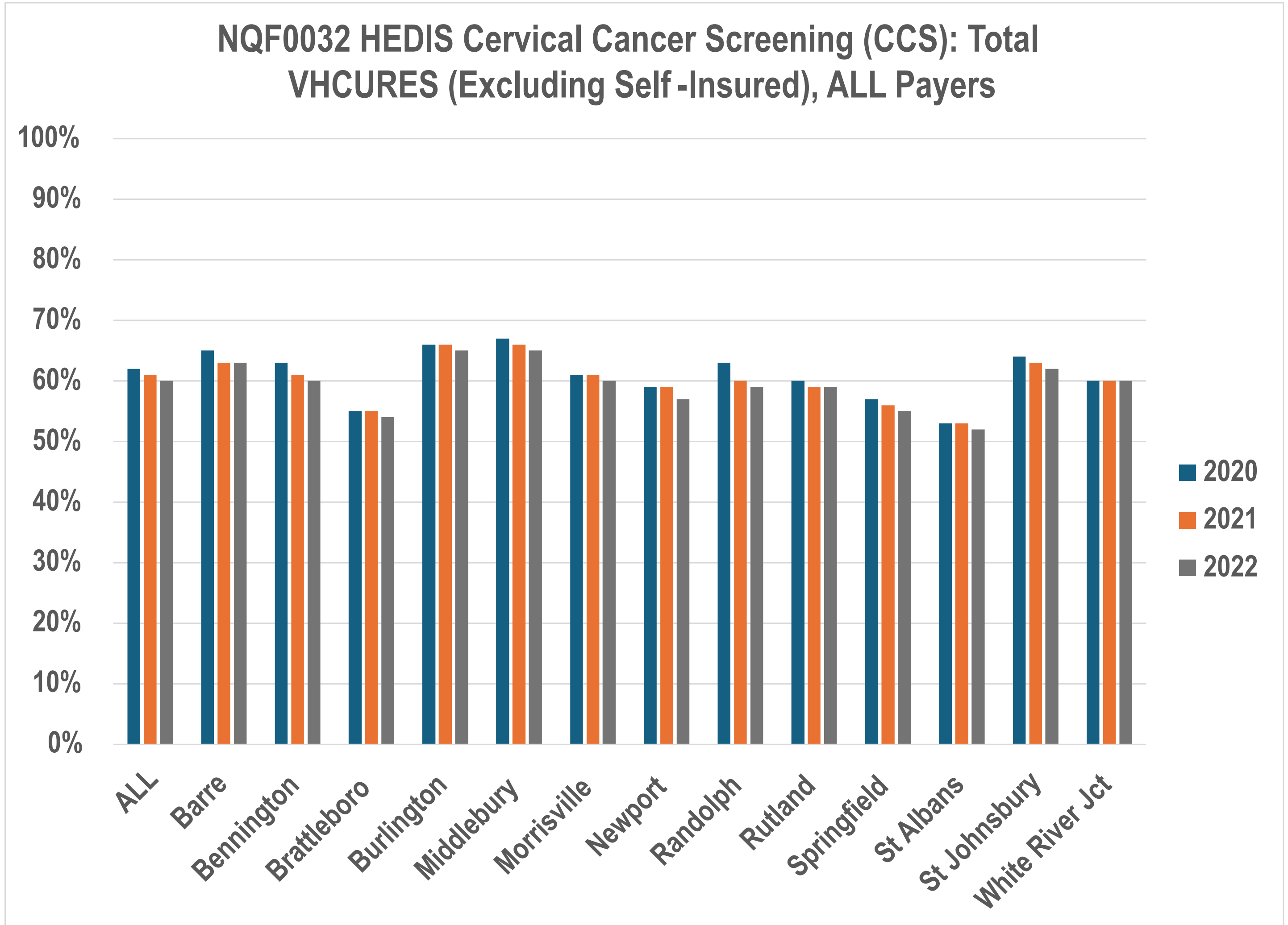


Chart 11 displays the percentage of women 21–64 years of age in the VHCURES population who were screened for cervical cancer using any of the following criteria by Hospital Service Area:

- Women 21–64 years of age who had cervical cytology performed within the last 3 years.
- Women 30–64 years of age who had cervical high-risk human papillomavirus (hrHPV) testing performed within the last 5 years.
- Women 30–64 years of age who had cervical cytology/high-risk human papillomavirus (hrHPV) cotesting within the last 5 years.

WOMEN'S PREVENTATIVE HEALTH CARE MEASURES

TOTAL VHCURES (EXCLUDING SELF-INSURED) POPULATION

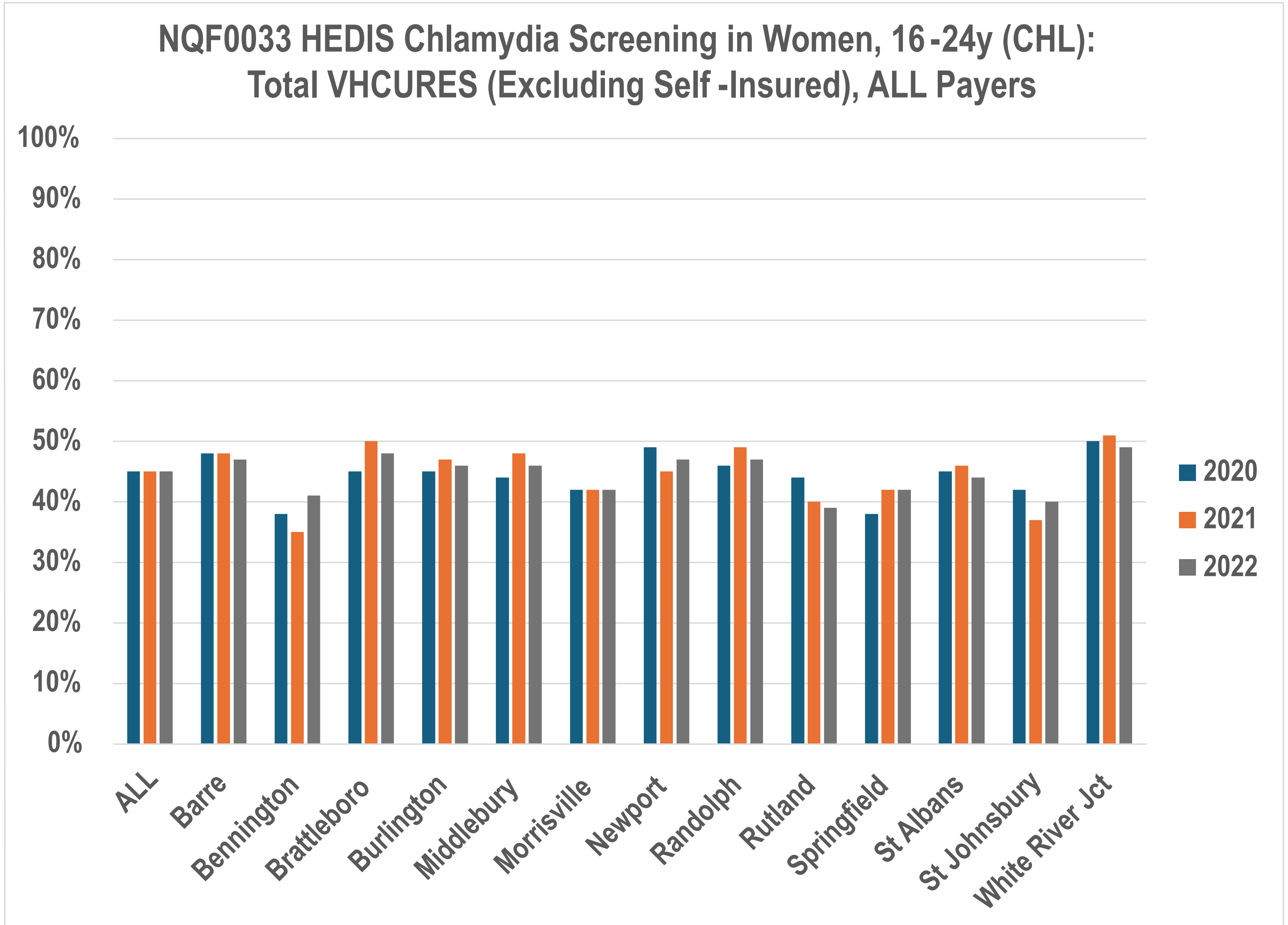


Chart 12 displays the percentage of women 16–24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year by Hospital Service Area.

ACCESS-TO-CARE AND HEALTH CARE UTILIZATION MEASURES

TOTAL VHCURES (EXCLUDING SELF-INSURED) POPULATION

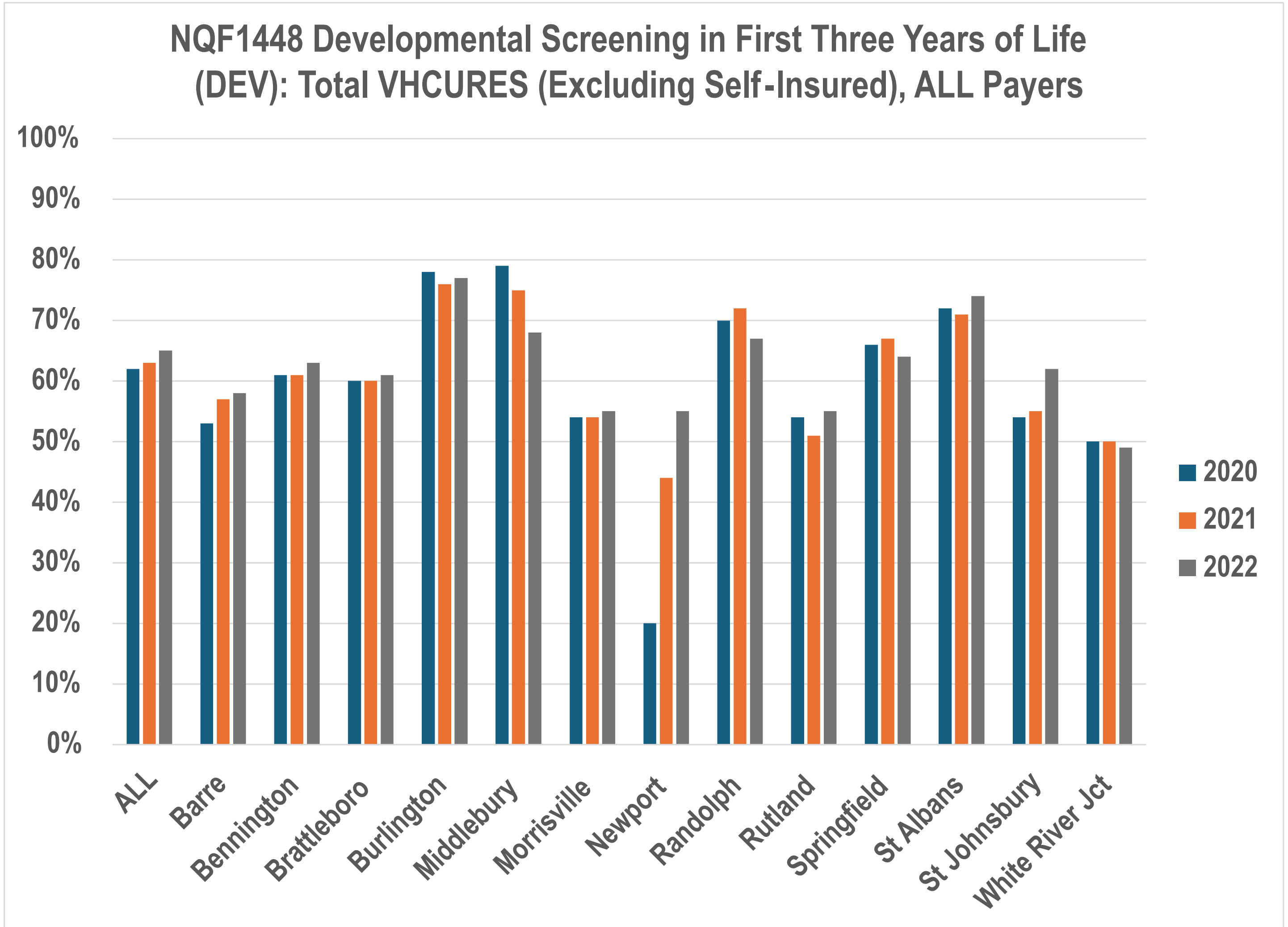


Chart 13 displays the percentage of children aged 3 or less in the VHCURES database who were screened for risk of developmental, behavioral, and social delays by the age of three by Hospital Service Area.

ACCESS-TO-CARE AND HEALTH CARE UTILIZATION MEASURES

TOTAL VHCURES (EXCLUDING SELF-INSURED) POPULATION

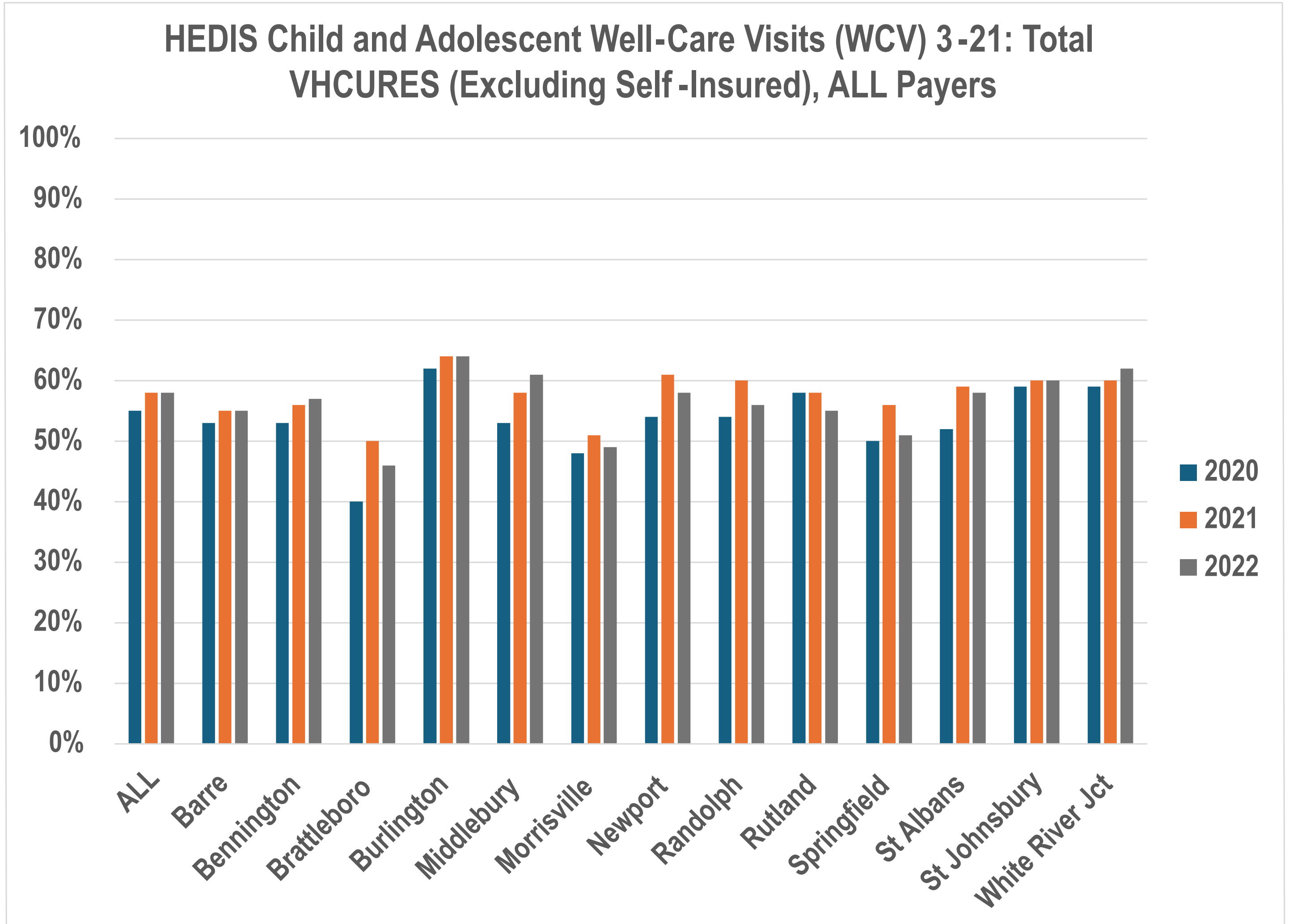


Chart 14 displays the percentage of adolescents 3–21 years old in the VHCURES database who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year by Hospital Service Area.

ACCESS-TO-CARE AND HEALTH CARE UTILIZATION MEASURES

TOTAL VHCURES (EXCLUDING SELF-INSURED) POPULATION

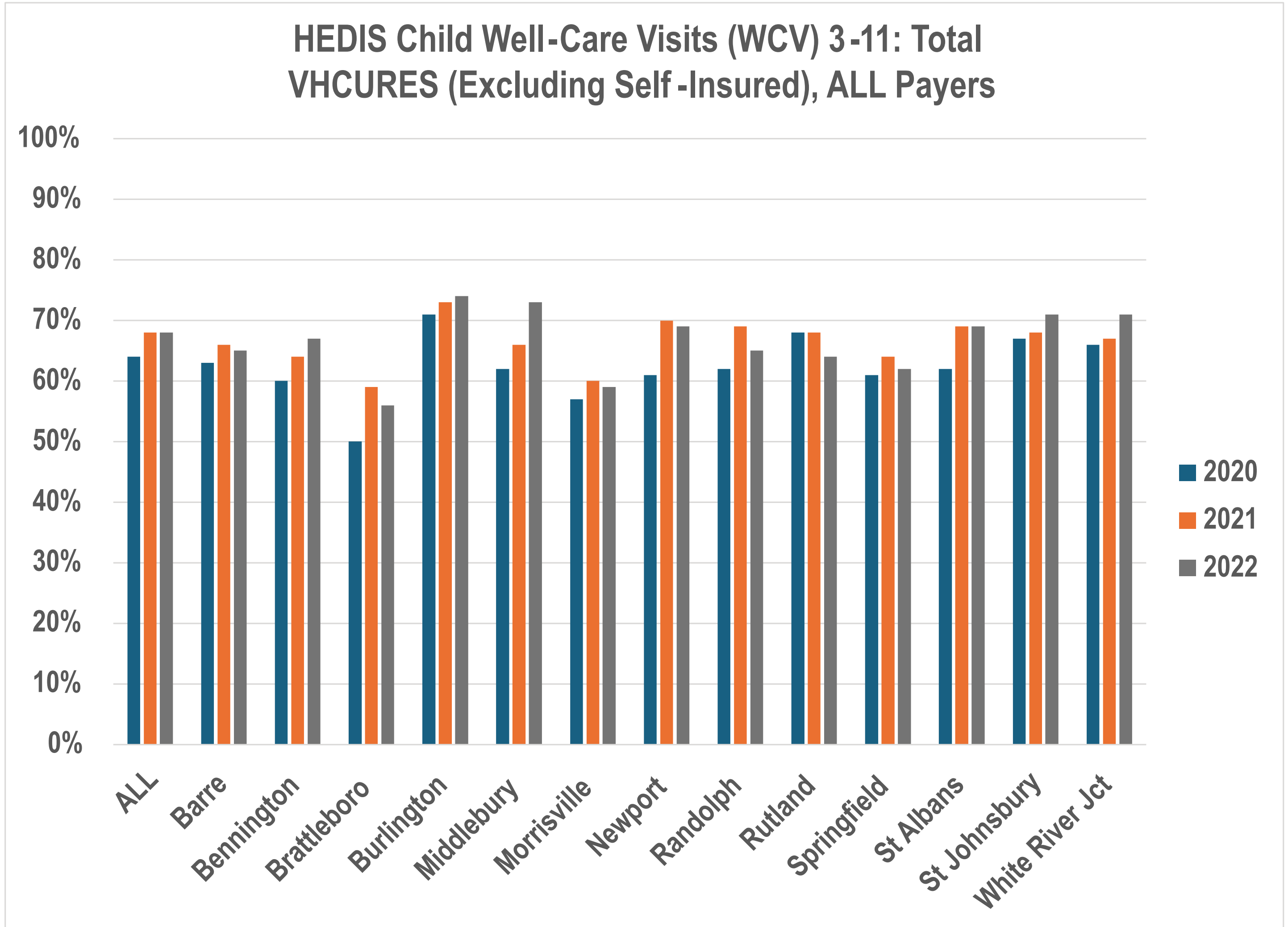


Chart 15 displays the percentage of children 3–11 years old in the VHCURES database who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year by Hospital Service Area.

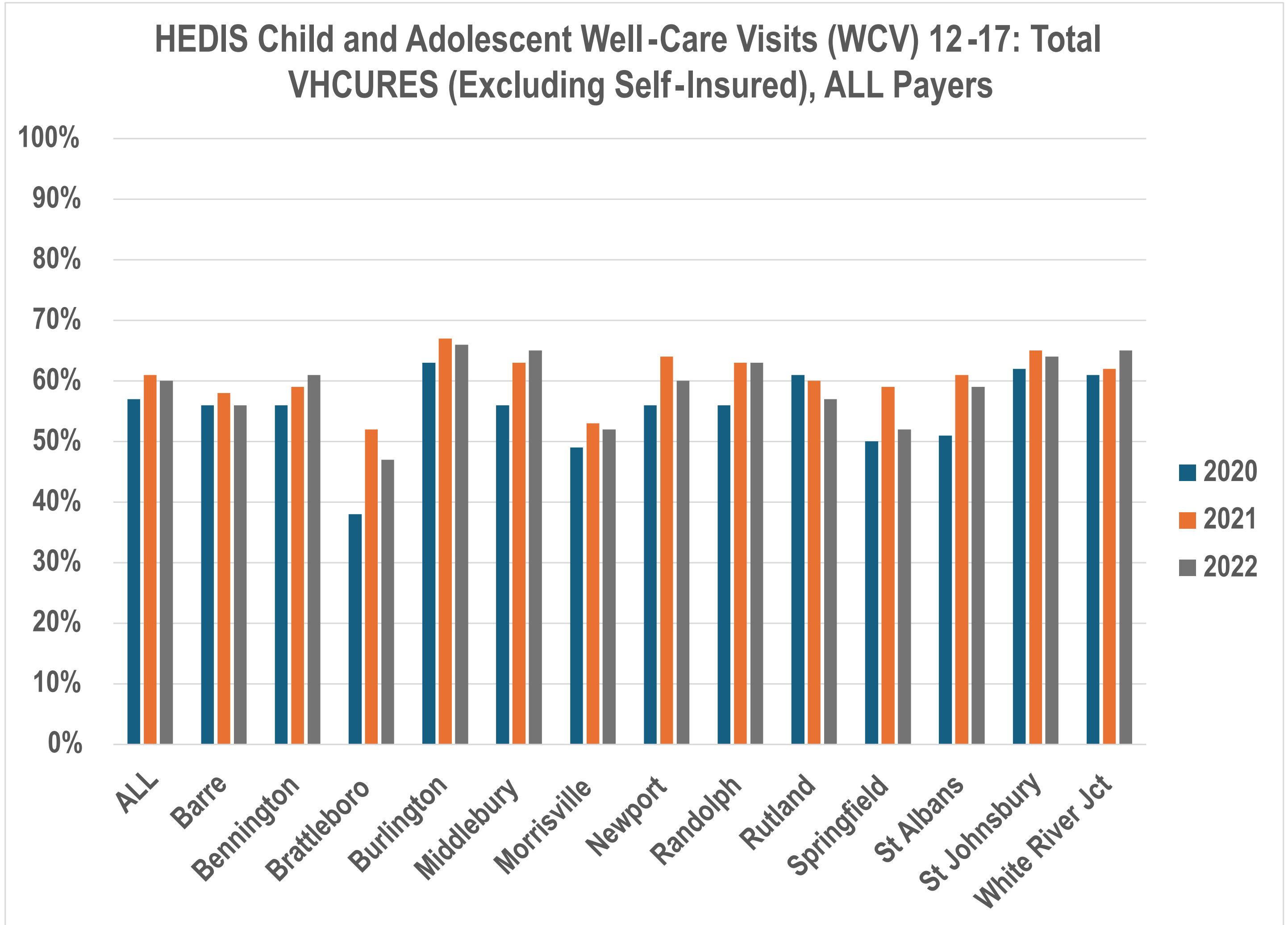


Chart 16 displays the percentage of adolescents 12–17 years old in the VHCURES database who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year by Hospital Service Area.

ACCESS-TO-CARE AND HEALTH CARE UTILIZATION MEASURES

TOTAL VHCURES (EXCLUDING SELF-INSURED) POPULATION

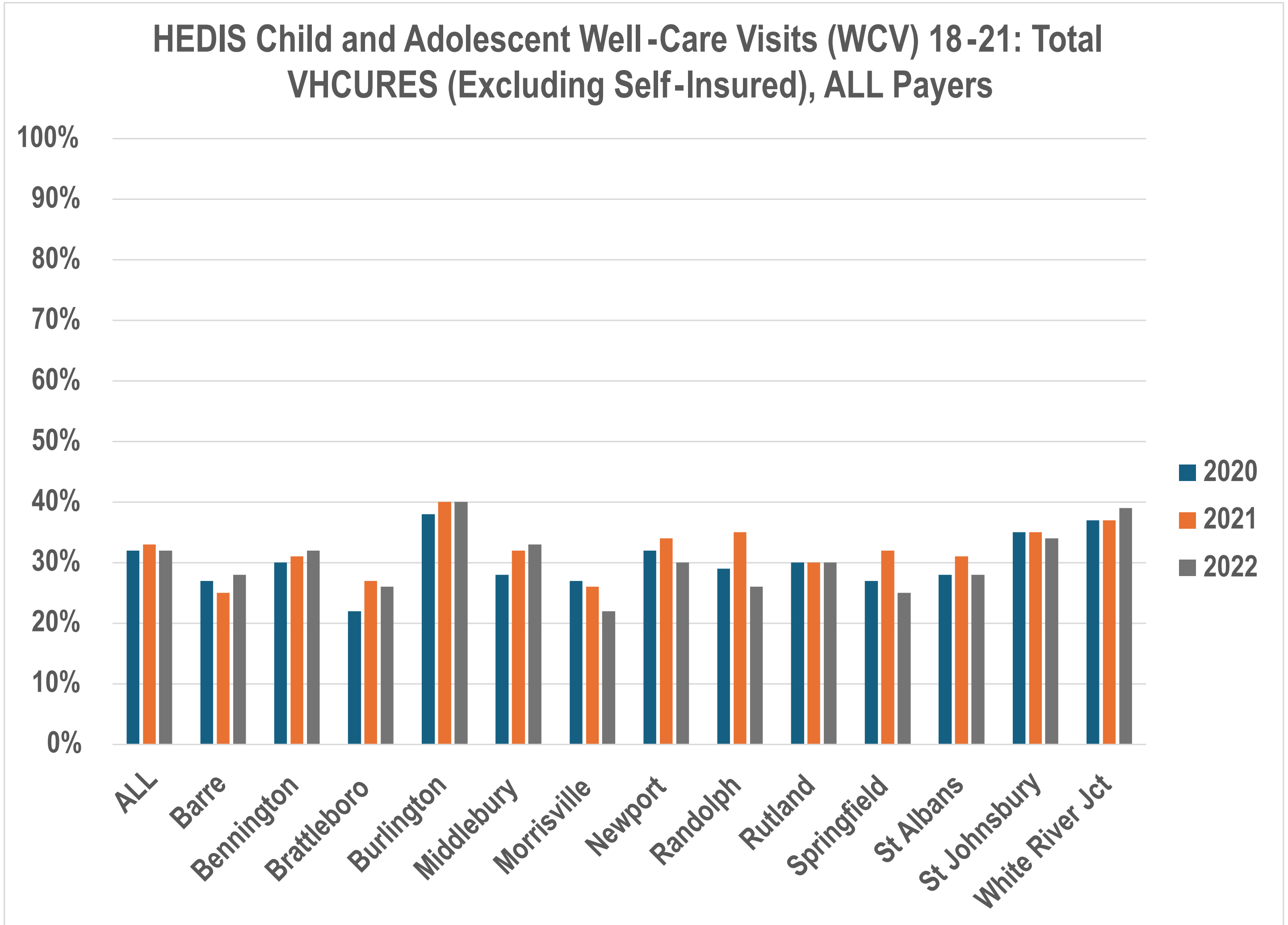


Chart 17 displays the percentage of adolescents 18–21 years old in the VHCURES database who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year by Hospital Service Area.

ACCESS-TO-CARE AND HEALTH CARE UTILIZATION MEASURES

TOTAL VHCURES (EXCLUDING SELF-INSURED) POPULATION

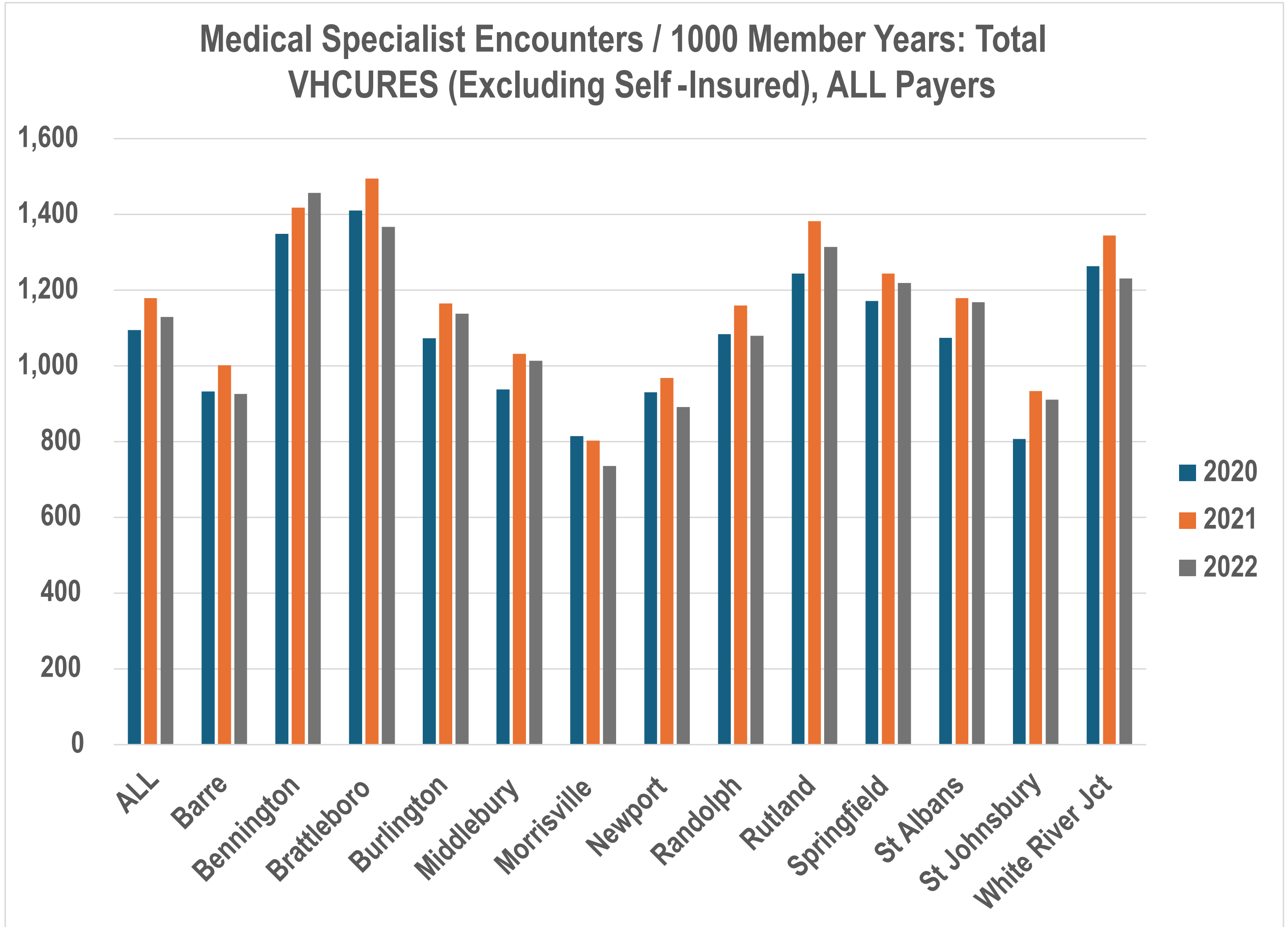


Chart 18 chart displays the risk-adjusted rate of medical specialist encounters per 1000 member-years for the VHCURES population by Hospital Service Area.

ACCESS-TO-CARE AND HEALTH CARE UTILIZATION MEASURES

TOTAL VHCURES (EXCLUDING SELF-INSURED) POPULATION

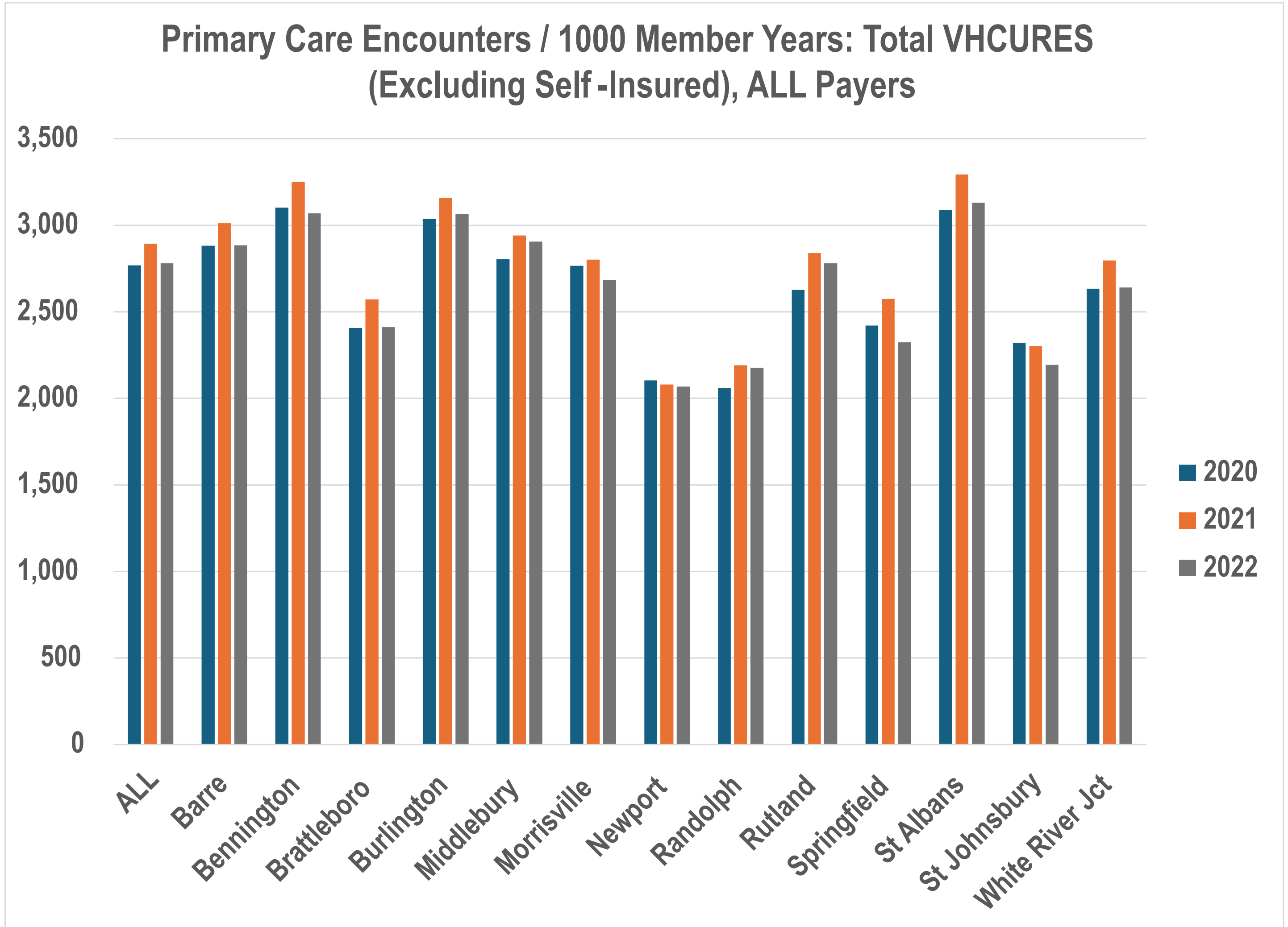


Chart 19 displays the risk-adjusted rate of primary care encounters per 1000 member-years for the VHCURES Population by Hospital Service Area.

ACCESS-TO-CARE AND HEALTH CARE UTILIZATION MEASURES

TOTAL VHCURES (EXCLUDING SELF-INSURED) POPULATION

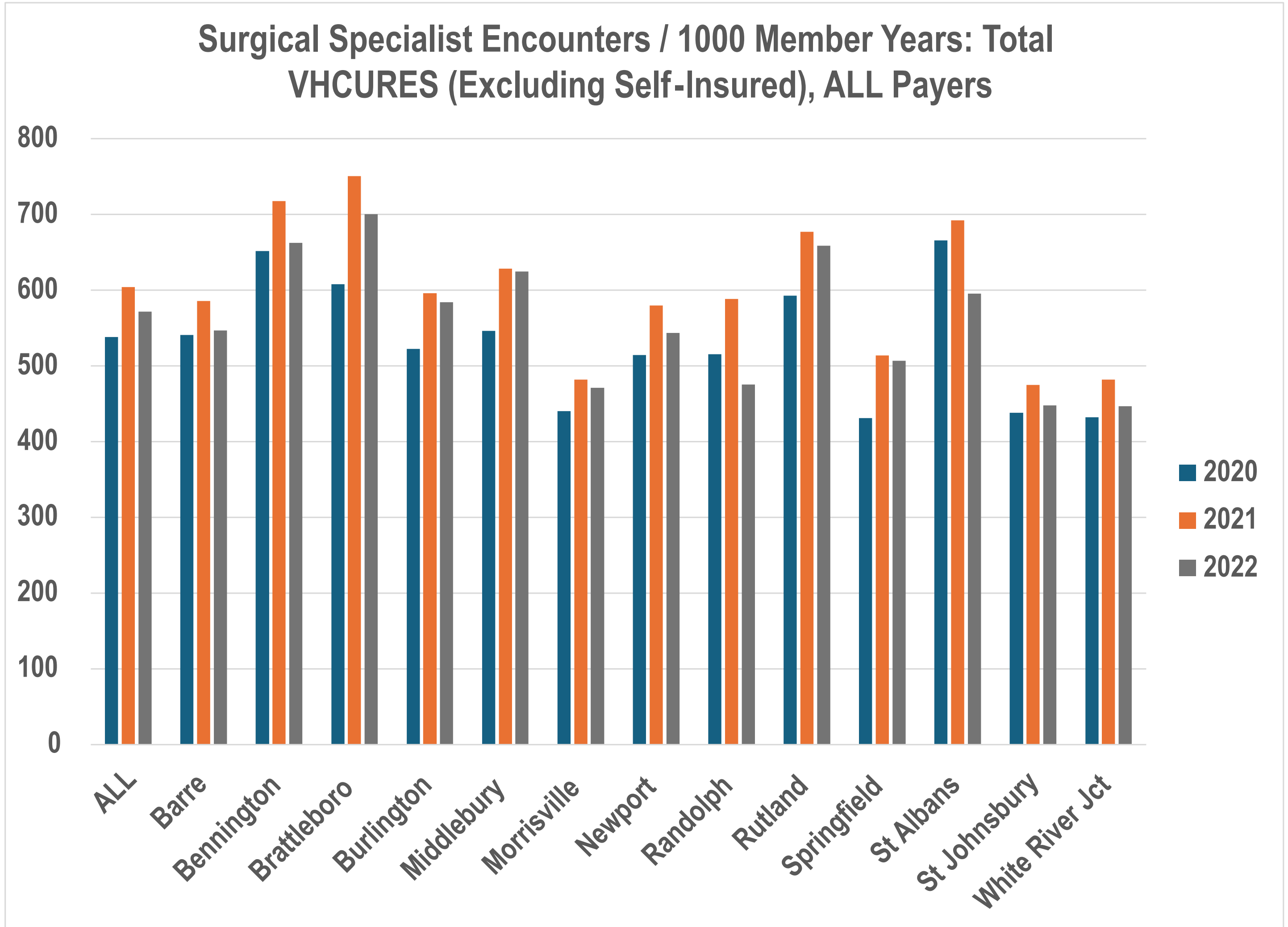


Chart 20 displays the risk-adjusted rate of surgical specialist encounters per 1000 member-years for the VHCURES Population by Hospital Service Area.

ACCESS-TO-CARE AND HEALTH CARE UTILIZATION MEASURES

TOTAL VHCURES (EXCLUDING SELF-INSURED) POPULATION

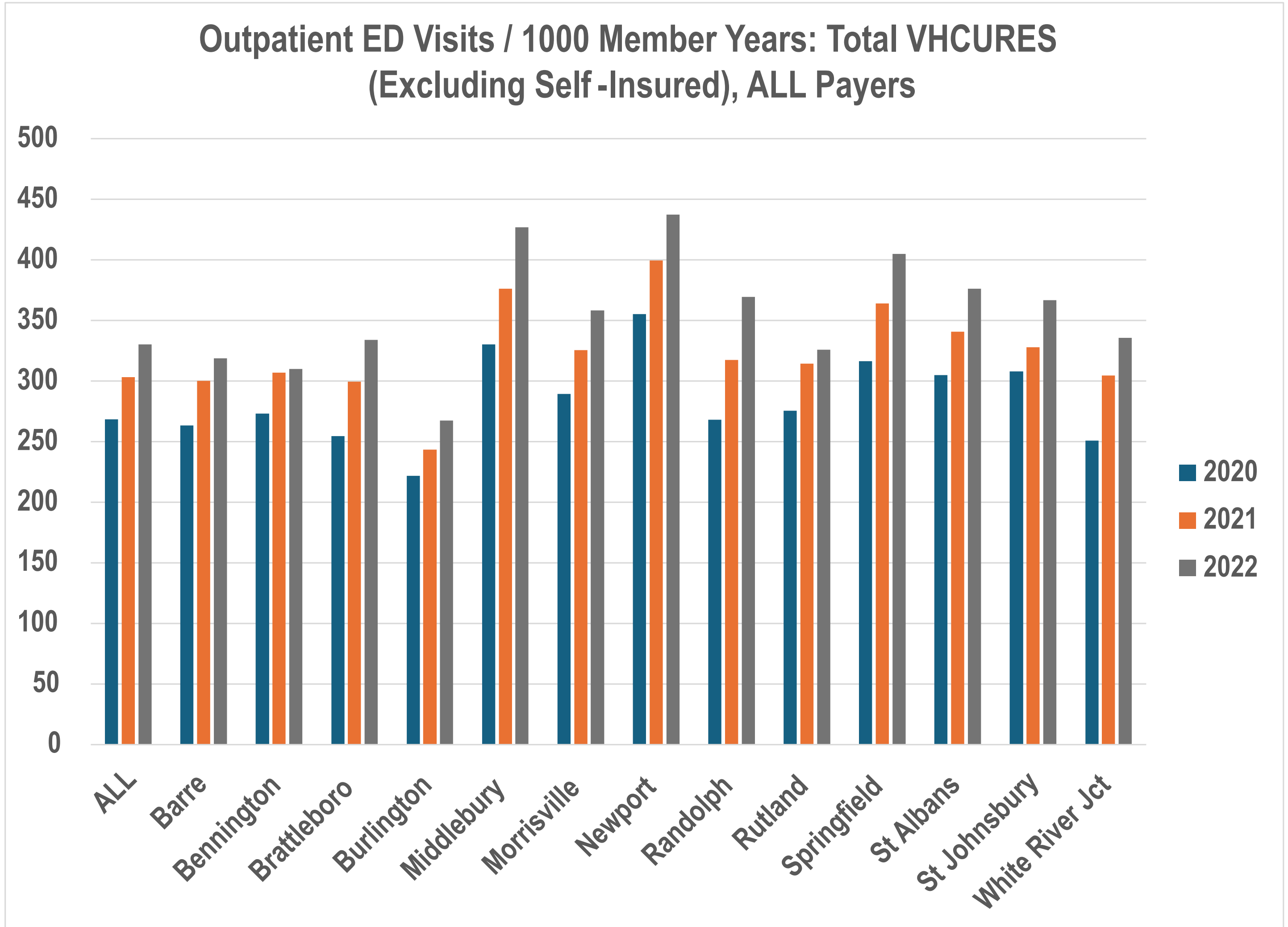


Chart 21 displays the risk-adjusted rate of outpatient emergency department visits per 1000 member-years for the VHCURES population by Hospital Service Area.

ACCESS-TO-CARE AND HEALTH CARE UTILIZATION MEASURES

TOTAL VHCURES (EXCLUDING SELF-INSURED) POPULATION

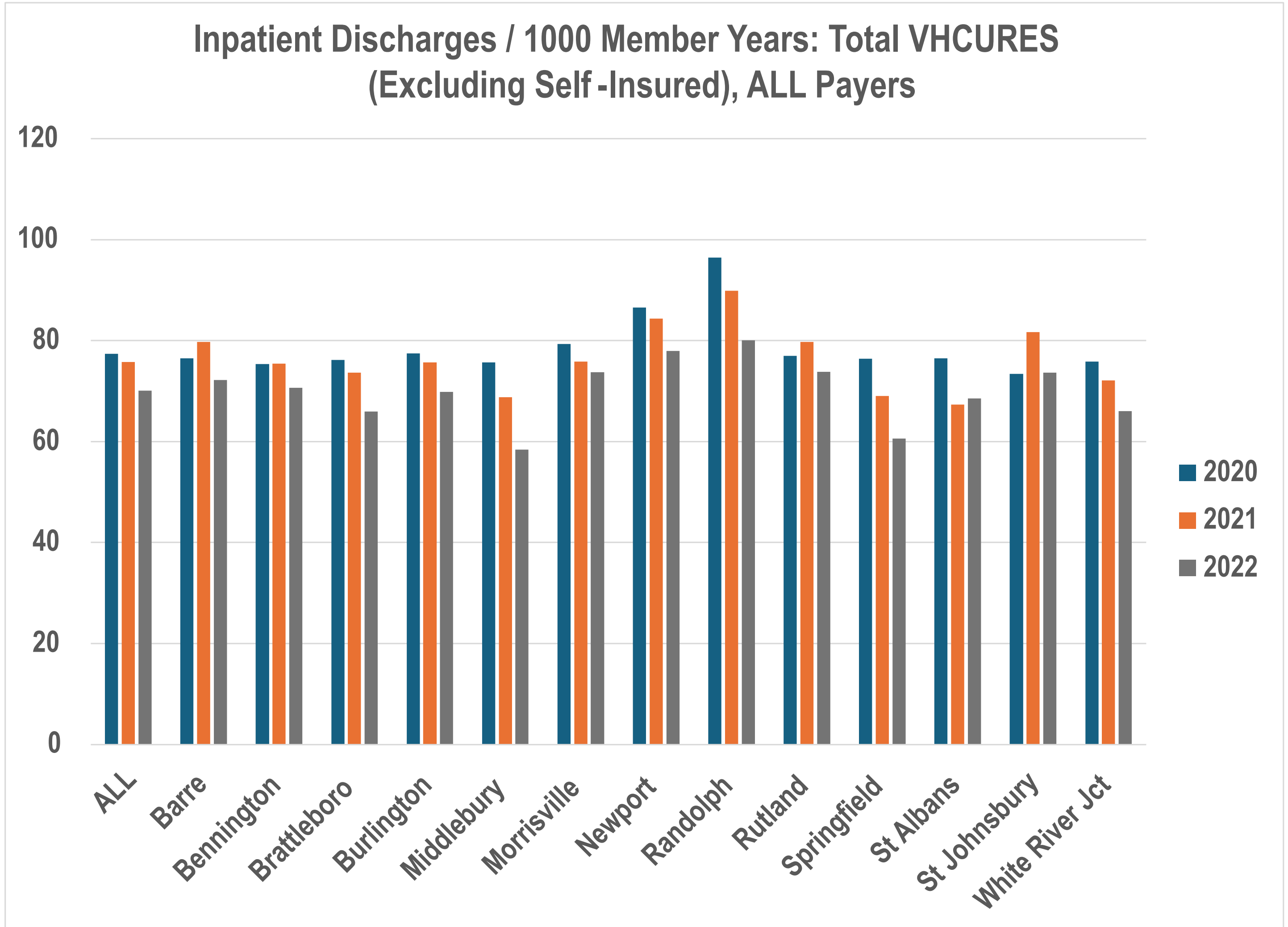


Chart 22 displays the risk-adjusted rate of inpatient discharges per 1000 member-years for the VHCURES population by Hospital Service Area.

MEASURES OF POTENTIALLY LOW-VALUE HEALTH CARE UTILIZATION

TOTAL VHCURES (EXCLUDING SELF-INSURED) POPULATION

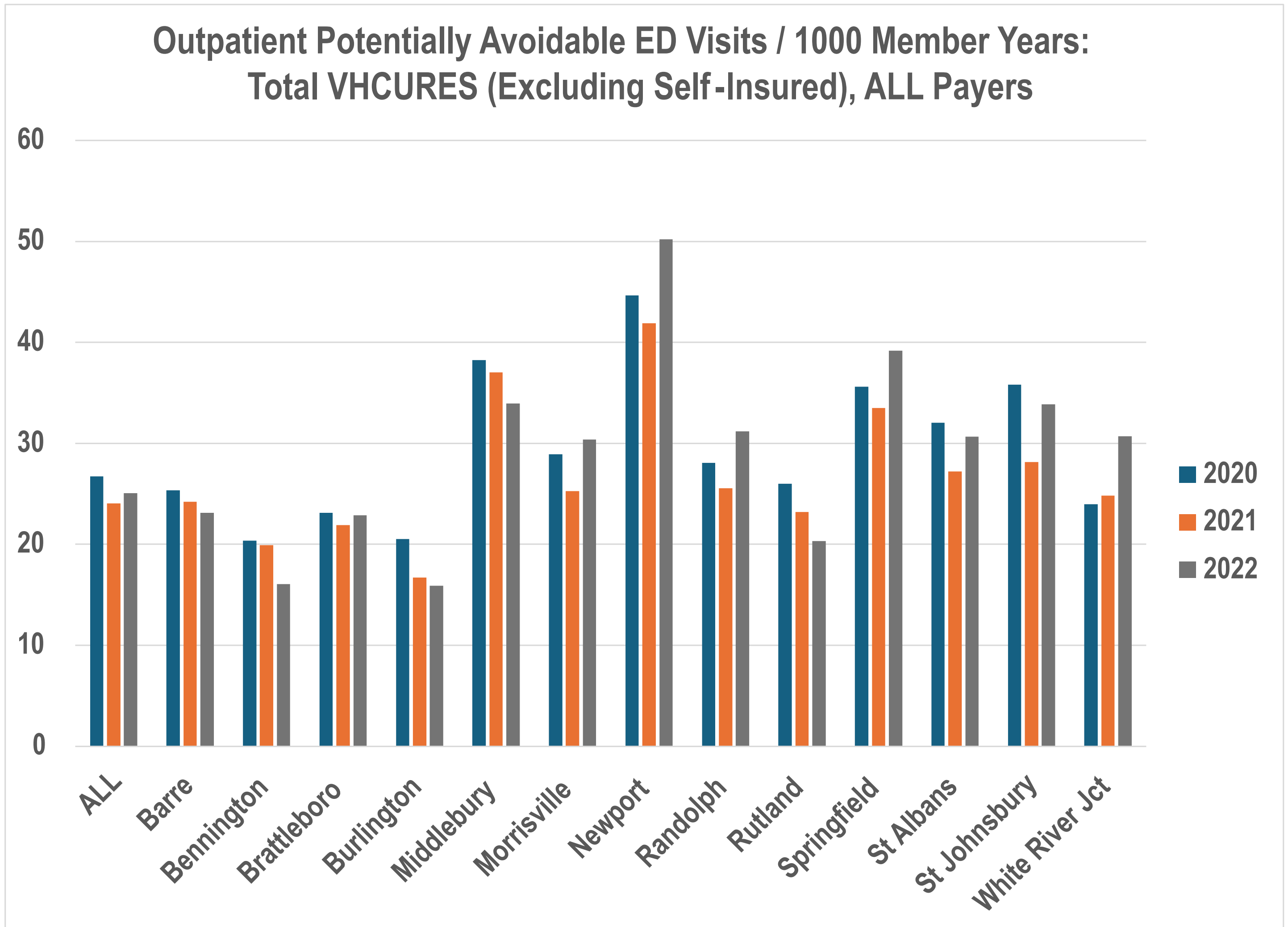


Chart 23 displays the risk-adjusted rate of potentially avoidable outpatient emergency department visits per 1000 member-years for the VHCURES population by Hospital Service Area. Avoidable ED visits are defined as ED visits with a primary diagnosis code that falls under an avoidable ED code set.

MEASURES OF POTENTIALLY LOW-VALUE HEALTH CARE UTILIZATION

TOTAL VHCURES (EXCLUDING SELF-INSURED) POPULATION

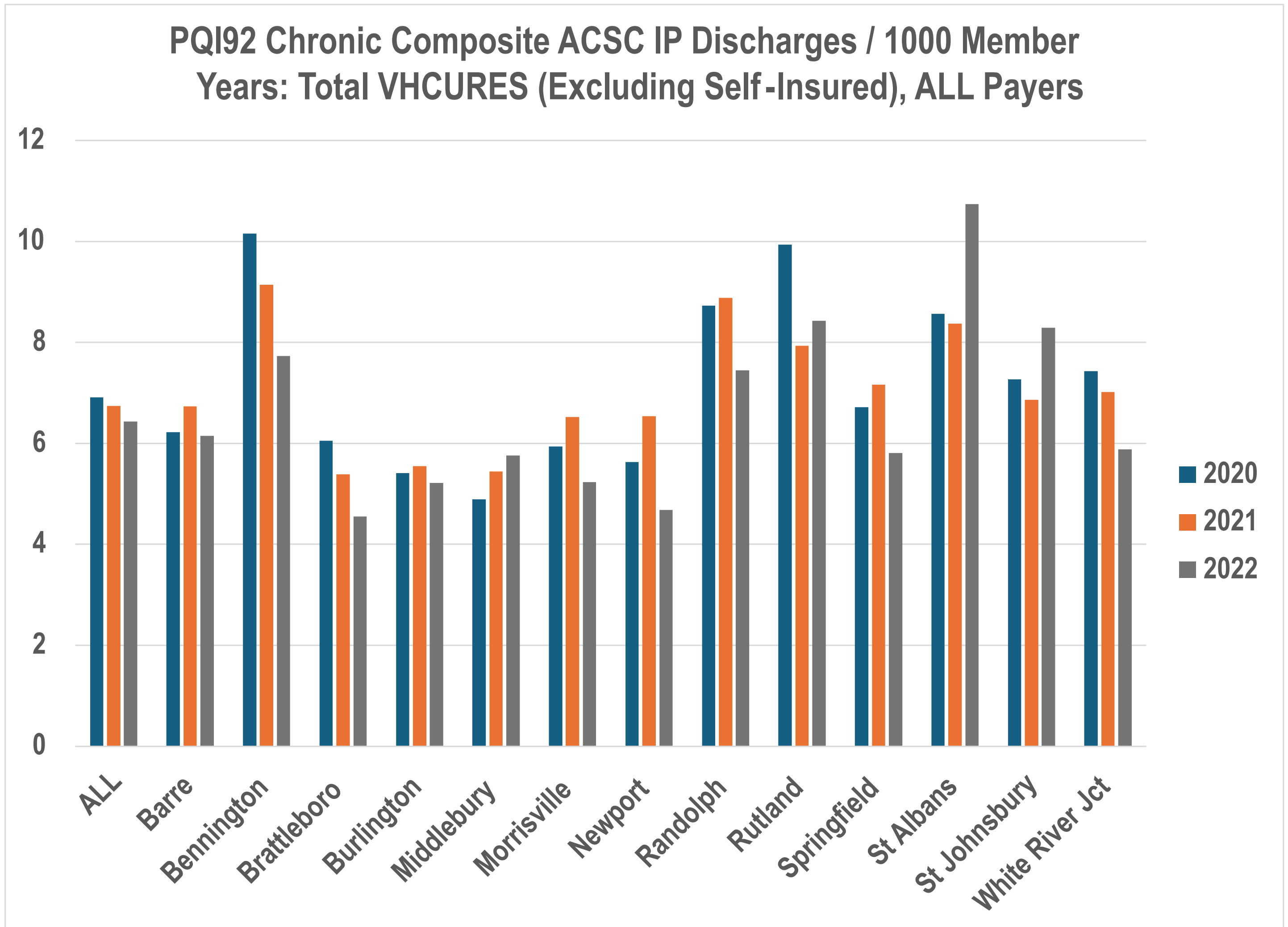


Chart 24 displays the risk-adjusted Prevention Quality Indicators (PQI) composite of chronic conditions per 100,000 people, ages 18 years and older, including people hospitalized with one of the following conditions:

1. Diabetes with short-term complications, diabetes with long-term complications;
2. Uncontrolled diabetes without complications, diabetes with lower-extremity amputation;
3. Chronic obstructive pulmonary disease, asthma, Hypertension, or heart failure.