REPORT TO THE VERMONT LEGISLATURE

Agency of Human Services

280 State Drive
Waterbury, VT
www.humanservices.vermont.gov

[*phone*] 802-241-0440
[*fax*] 802-241-0450

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

Submitted by: Jenney Samuelson
Secretary, Agency of Human Services

Prepared by: Dr. John M. Saroyan
Executive Director, Blueprint for Health

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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.

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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 (QI) 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 Mental Health Integration (MHI) into Primary Care Pilot Program to address mental health, substance use disorder, and social determinants of health within primary care.

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. Since 2008, Vermont has adopted and evolved with this model of care, with 126 practices achieving or sustaining recognition as a PCMH in 2025. The 2025 annual reporting requirements build on previous years' frameworks for model implementation and introduced more specific and detailed measures. Notable changes in 2025 included:

- A greater emphasis on comprehensive health assessments, covering a broader range of health determinants.
- Increased specificity in care management criteria, with a stronger focus on evidence-based care plans and patient-provider collaboration.

Community Health Teams

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, brief mental health interventions, facilitating connections to other health and human service providers, and numerous other interventions free of charge and without regard to insurance status. Currently, there are a total of 201 staff (115.76 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. The number of active, full-time equivalent CHT staff providing mental health or SUD patient care has more than tripled since the MHI Pilot started, from 8.3 in 2023 to 28.1 as of Dec 2025.

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 2025, practices continued to improve the capacity to track patients, encounters, and payers without compromising patient confidentiality.

Transformation

In 2025, Blueprint for Health played a central role in Vermont's Care Transformation initiative by convening hospitals and health care partners across the state, identifying shared challenges, and advancing collaborative strategies to strengthen access, quality, and sustainability. Working with the Health Care Reform leadership, Blueprint leveraged its regional infrastructure to support discussions on regulatory and financial pressures, hospital-to-hospital transfers, Electronic Medical Record (EMR) interoperability, group purchasing, clinical service redesign, and workforce needs. It also helped lead the Acuity, Capacity, and Transfer Management workstream, aimed at improving the efficiency of hospital and Emergency Medical Services (EMS) resources through a more integrated statewide approach. By aligning hospitals and community partners with statewide transformation goals, Blueprint served as a key integrator and implementation partner. This work established a strong foundation for 2026, when Blueprint will continue to guide regional planning, provide technical support, and assist hospitals in finalizing their transformation plans to build a more coordinated, resilient health care system for all Vermonters.

[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 2024 through September 2025, the Department of Health and the Blueprint offered 49 workshops, with a total of 201 individuals completing a program. The Diabetes Prevention Program had the largest number of individuals completing a workshop.

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 2025 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 Mental Health Integration (MHI) into Primary Care pilot to address mental health, substance use disorder, and social determinants of health (SDOH) within primary care.

While the Blueprint 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 2025.

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 are no vacancies on the Blueprint Executive Committee. The committee met six times in 2025, 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

1. Mental Health Integration into Primary Care

In coordination with the Agency of Human Services (AHS) Secretary, Department of Health, Department of Mental Health, Department of Vermont Health Access, and Director of Health Care Reform, the Blueprint staff developed the Mental Health Integration (MHI) Pilot in 2023. The Pilot, now entering its third year, makes payments to CHTs so that Health Service Area Administrative Entities (AEs) can expand vital services to address the mental health and substance use needs of the population in an integrated way. MHI Pilot CHTs include additional staff serving as Mental Health and Substance Use Counselors, Community Health Workers, and Social Workers.

As of November 15, 2025, a total of 119 practices (representing 93% of PCMHs in Vermont) attested to participate in Year 2 of the Pilot.

CHT positions filled using MHI funding are tracked centrally. As of November 15, 2025, a total of 62.2 FTE staff positions are currently providing care thanks to the MHI funding, including 36.2 FTE of community health workers and 21.6 FTE team members working in mental health or substance us patient care. All HSAs have hired staff, giving the Pilot statewide reach.

In 2025, the Blueprint completed an intensive training program associated with the MHI initiative. A total of 1,096 people attended trainings in Motivational Interviewing (73), Structural Competence and Cultural Humility (62), Community Health Workers in a Primary Care Setting (19), Foundations for Community Health Worker Supervision and Support (15), Bridges Out of Poverty (62), Working with 2SLGBTQ+ Peoples (160), and a series of 12 pediatric trainings held in partnership with Developmental Understanding and Legal Collaboration for Everyone (DULCE) (686, see below). The Central Office also engaged with Agency of Human Services teams to support team-based care in each HSA with community partners to support patients with complex medical and social needs. These trainings, as webinars, are now available in the Blueprint online learning management system.

[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.

2. Care Transformation Support and Leadership

Act 68 of 2025 tasked AHS with facilitating collaboration and coordination among providers while reducing costs and developing a Statewide Health Care Delivery Strategic Plan. In 2025, Blueprint for Health played a central role as a statewide driver of innovation, supporting Vermont's Care Transformation initiative and convening hospitals and health care stakeholders for coordinated regional planning. At the request of the AHS, Blueprint partnered with Health Care Reform (HCR) leadership to organize a series of regional meetings using its established network of Program Managers and Quality Improvement Facilitators. These meetings brought together hospitals, AHS, and community partners to advance system-wide strategies for improving access, quality, and sustainability.

Launching Regional Hospital Engagement

Initial Blueprint-facilitated regional meetings held in August and September 2025 focused on candid conversations among hospital leaders about shared challenges, opportunities for collaboration, and innovative approaches to ensuring high-quality, affordable care for Vermonters. Consistent themes emerged that informed both statewide strategy and the development of Vermont's HR1 application. These themes led to targeted workstreams in:

- Regulation and financing (including antitrust navigation, growth regulation, and uncompensated care pressures)
- Hospital-to-hospital transfers and capacity management
- Electronic medical record interoperability and potential EMR unification
- Group purchasing and opportunities for shared services
- Clinical service redesign (e.g., centers of excellence, OR management, ambulatory specialty services, call coverage models)
- Workforce recruitment and training

Advancing Regional Alignment and Collaboration

Throughout November and December, Blueprint supported continued regional discussions to align hospitals and partners around strategies to improve access and quality, particularly in areas where demand exceeds supply, workforce shortages affect cost and service delivery, or patient acuity requires care in more appropriate settings.

Acuity, Capacity, and Transfer Management Workstream

Blueprint and the Office of Health Care Reform leadership played key roles in the Acuity, Capacity, and Transfer Management workstream, aimed at improving the efficiency of Vermont's hospital and EMS resources. AHS convened stakeholders to develop statewide, system-integrated transfer strategies that ensure responsible bed utilization while preserving patient safety, proximity to home, and fiscal health. The work identified root causes of hospital capacity challenges and informed a set of recommended strategies that communities will refine and implement through their transformation plans.

Blueprint's Ongoing Role

Blueprint continues to serve as a critical integrator, convener, and implementation partner—linking hospitals, community providers, and statewide transformation goals. Its regional infrastructure and collaborative leadership are foundational to Vermont's shift toward an interconnected, sustainable health care system. The work completed in 2025 lays the groundwork for broader provider and community engagement planned for 2026.

Blueprint's Focus for 2026

Facilitating Regional Planning and Collaboration

- Supporting regional planning structures and coordinated conversations
- Helping hospitals identify stakeholders and community partners for each transformation goal
- Working with AHS to address regulatory barriers, strengthen analytics, and redesign care pathways

Providing On-the-Ground Infrastructure for Transformation

Through Regional Facilitators, Program Managers, and Quality Improvement staff, Blueprint will:

- Extend regional discussions beyond hospital leadership
- Bring frontline, community-based expertise to transformation planning
- Translate statewide priorities into actionable, locally grounded strategies

Supporting Hospital Transformation Plans

As hospitals finalize draft transformation plans in early 2026, Blueprint will:

- Convene discussions with hospitals and community partners
- Ensure plans reflect broad, multi-provider input
- Help guide strategic opportunities identified through 2025–2026 regional engagement

3. Developmental Understanding and Legal Collaboration for Everyone (DULCE)

Vermont's DULCE program is overseen by the Vermont Department of Health (VDH), Division of Family and Child Health (DFCH). The Blueprint and VDH built a pediatric model that took components of the DULCE approach and extended the work beyond six months of age to provide universal screening, referrals, and supports to practices that serve families with children ages 0–17. During the two-year pilot from July 1, 2023 through June 30, 2025, 1,067 babies and their families were served through the DULCE program.

In addition to the implementation of the DULCE program, DCFH designed a year-long pediatric training series for the Blueprint for Health network. The monthly trainings were attended by 40–50 individuals per session, and included providers, practice managers, nurses, CHT staff, and QI Facilitators.

DFCH also worked with the Vermont Child Health Improvement Program (VCHIP) to host a Blueprint-specific training in the Touchpoints Approach. Touchpoints-informed practice is proven effective in a variety of organizations and settings, including early care and education centers, pediatric healthcare, mental health, early intervention and home visitation, child welfare, public health, institutions of higher learning, and Tribal communities.

4. Mental Health Integration (MHI) Pilot Evaluation

A qualitative evaluation of the Mental Health Integration Pilot by Market Decisions Research has been completed. The final report is available on the Blueprint's MHI webpage. The qualitative evaluation includes interviews and focus groups with patients, families and caregivers, providers, CHT staff, and AE 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 and a difference-in-difference study of Medicaid claims data are also underway. These quantitative evaluations focus on insights available from claims data. Results are anticipated in early 2026, depending on release dates of claims data from insurers.

III. PROGRAMMATIC UPDATES

A. Patient-Centered Medical Homes

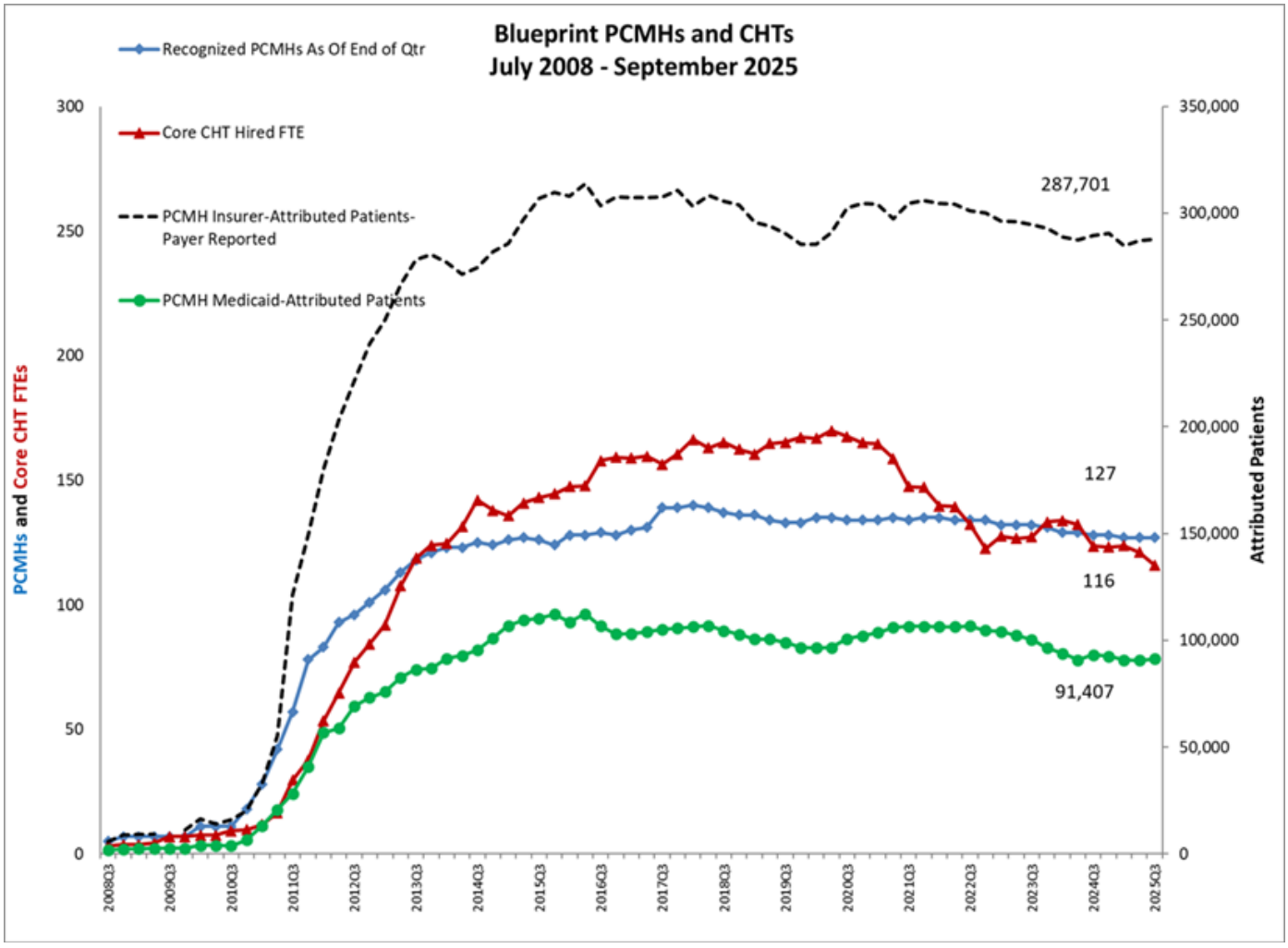
The Patient-Centered Medical Home (PCMH) is a model of care that has transformed how primary care is organized and delivered in Vermont. Since 2008, Vermont has adopted and evolved with this model of care, with 124 practices achieving or sustaining recognition as a PCMH in 2025.

The 2025 annual reporting requirements build on previous year's frameworks for model implementation and introduced more specific and detailed measures. Notable changes in 2025 included:

- A greater emphasis on comprehensive health assessments, covering a broader range of health determinants.
- Increased specificity in care management criteria, with a stronger focus on evidence-based care plans and patient-provider collaboration.

Building on the 2024 requirement for practices to adopt and utilize electronic clinical measurement (eCQM), Blueprint participating PCMHs continued to use standardized, electronically reported quality measures that assisted with identifying opportunities for the practice to track patient outcomes, adherence to evidence-based guidelines, and population health trends and meet PCMH submission requirements. Measures that multiple practices focused on included:

- CMS 2—Screening for Depression and Follow-up Plan
- CMS-147—Influenza Immunization
- CMS-154—Appropriate Treatment for Upper Respiratory Infection
- CMS-165—Controlling High Blood Pressure
- CMS-68—Documentation of Current Medications in the Medical Record.



Three previously recognized PCMHs were consolidated with other practice locations in their FQHC or Hospital-Owned Practices, and one single provider practice retired. One naturopathic practice completed a new transformation into a PCMH in 2025.

One hundred twenty-three (123) practices sustained recognition as PCMHs in 2025 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 standards, 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 QI 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 2023 and 2024. Only three practices were randomly selected for an in-depth NCQA audit in 2025. This evolution of the recognition process has allowed for a greater focus on continuous QI 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 2026. 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 (QI) Facilitation

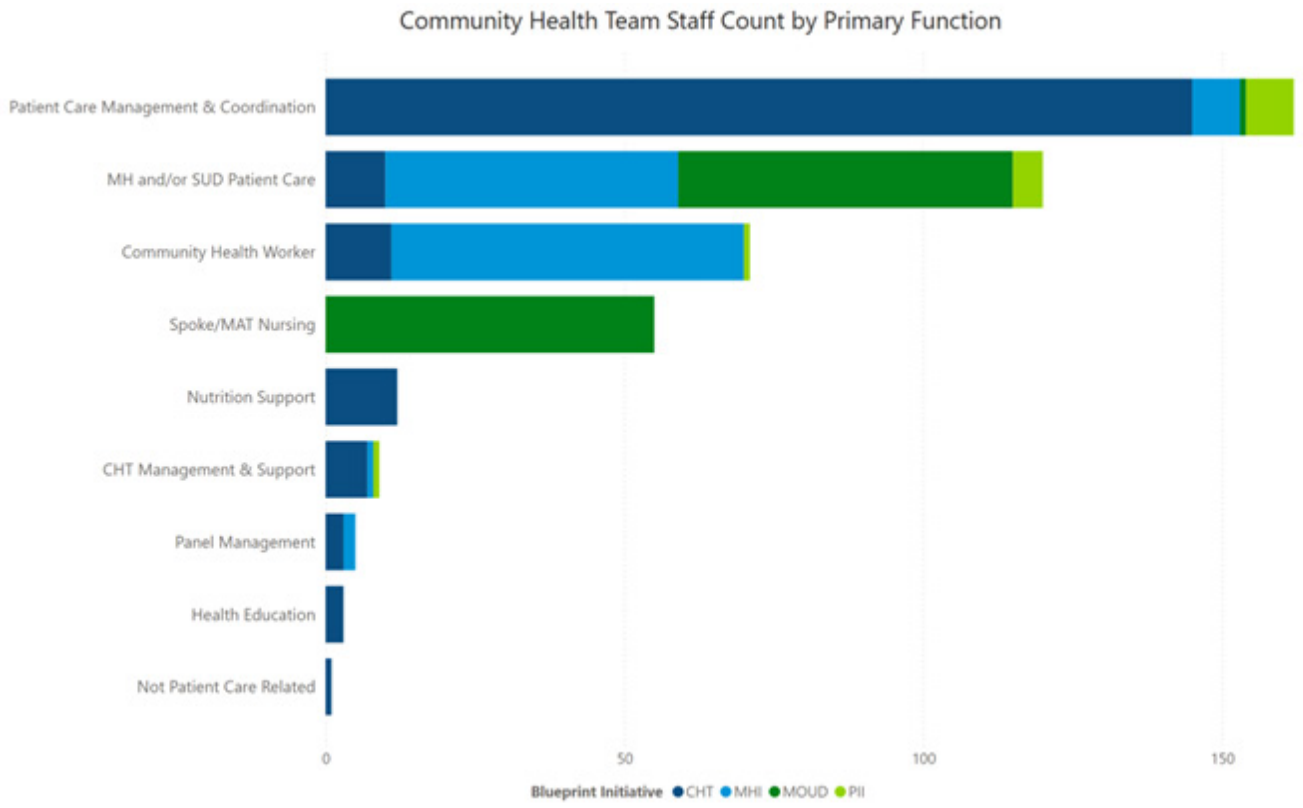
The Blueprint currently offers participating practices the services of a QI Facilitator. QI facilitators support practices by focusing on implementation of evidence-based care or models of care to improve patient outcomes and experiences. QI Facilitators are highly skilled in quality planning (using 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).

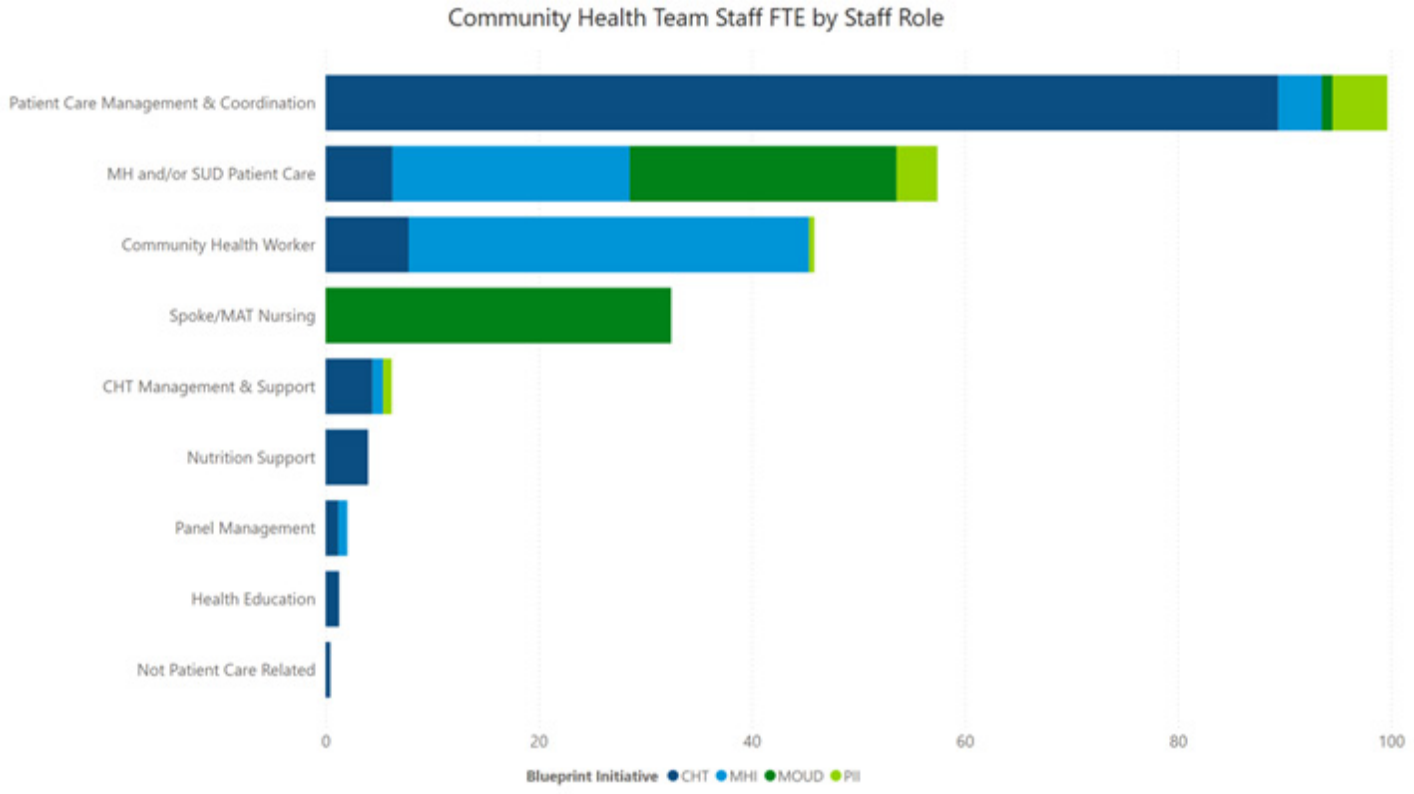
Presently, there are thirteen QI Facilitators (13 FTE) assigned to work with Blueprint-participating practices in a geographic area. General QI Facilitators are considered local experts in the PCMH Model and coach practices to achieve and retain NCQA recognition. These facilitators work on an ongoing 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.

C. Community Health Team (CHT) Data

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 social drivers of health 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 in a team-based care model 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 2025 are highlighted below.

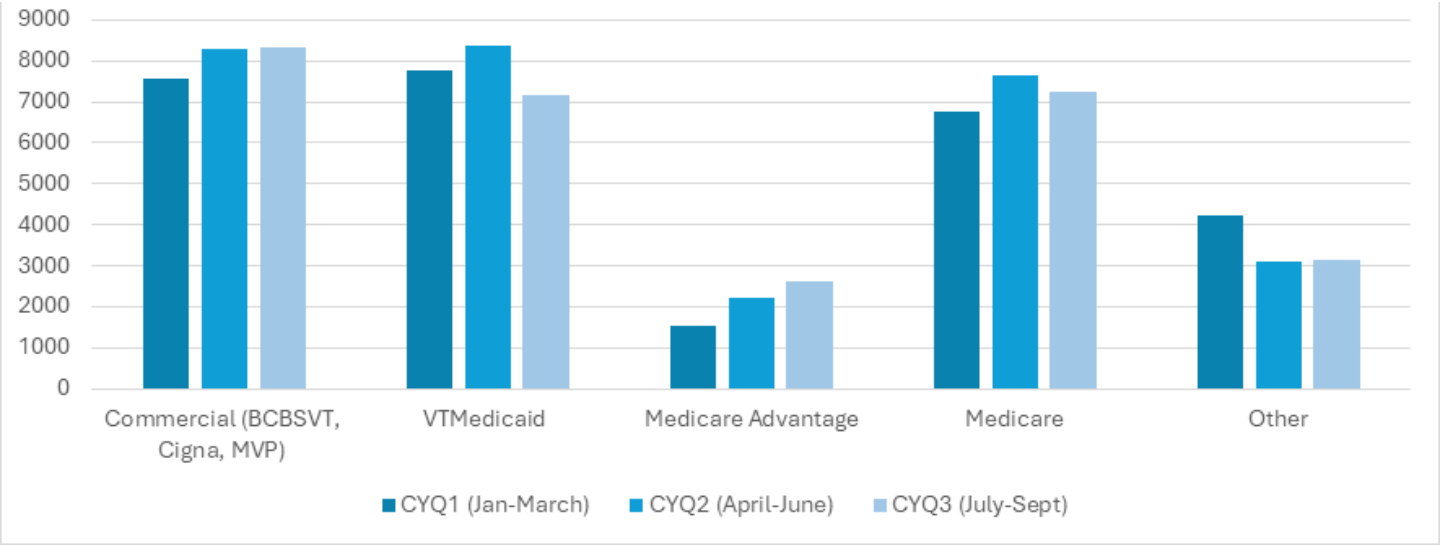
In 2022, the Blueprint began to track the numbers of patients served by CHT staff, including their insurance type where possible, for the first time. This information indicated that Community Health Teams serve individuals with a variety of insurance types, highlighting the importance of the Blueprint's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


Community Health Team Staff Count by Primary Function
Patient Care Management & Coordination
MH and/or SUD Patient Care
Community Health Worker
Spoke/MAT Nursing
Nutrition Support
CHT Management & Support
Panel Management
Health Education
Not Patient Care Related
0
50
100
150
Blueprint Initiative CHT MHI MOUD PII


Community Health Team Staff FTE by Staff Role
Patient Care Management & Coordination
MH and/or SUD Patient Care
Community Health Worker
Spoke/MAT Nursing
CHT Management & Support
Nutrition Support
Panel Management
Health Education
Not Patient Care Related
0
20
40
60
80
100
Blueprint Initiative CHT MHI MOUD PII

Health Service Area	Calendar Quarter 2025	Commercial (BCBSVT, Cigna, MVP)	VT Medicaid	Medicare Advantage	Medicare	Other	TOTAL
Barre	CYQ1 (Jan-March)	259	361	214	456	133	1423
Barre	CYQ2 (April-June)	253	353	222	452	147	1427
Barre	CYQ3 (July-Sept)	250	338	229	512	144	1473
Bennington	CYQ1 (Jan-March)	447	604	0	396	260	1707
Bennington	CYQ2 (April-June)	408	546	27	347	103	1431
Bennington	CYQ3 (July-Sept)	318	477	218	226	120	1359
Brattleboro	CYQ1 (Jan-March)	208	209	80	530	142	1169
Brattleboro	CYQ2 (April-June)	179	294	102	458	124	1157
Brattleboro	CYQ3 (July-Sept)	179	186	119	472	119	1075
Burlington	CYQ1 (Jan-March)	4468	3064	918	1631	1655	11736
Burlington	CYQ2 (April-June)	4694	3319	873	1535	1155	11576
Burlington	CYQ3 (July-Sept)	4763	3135	1087	1531	1232	11748
Middlebury	CYQ1 (Jan-March)	534	474	209	458	155	1830
Middlebury	CYQ2 (April-June)	1049	937	865	1586	204	4641
Middlebury	CYQ3 (July-Sept)	1006	87	815	1445	319	3672
Morrisville	CYQ1 (Jan-March)	282	327	0	442	125	1176
Morrisville	CYQ2 (April-June)	225	295	0	401	104	1025
Morrisville	CYQ3 (July-Sept)	368	477	0	161	78	1084
Newport	CYQ1 (Jan-March)	186	166	0	241	116	709
Newport	CYQ2 (April-June)	191	319	0	259	103	872
Newport	CYQ3 (July-Sept)	182	164	0	244	110	700
Randolph	CYQ1 (Jan-March)	110	227	11	194	86	628
Randolph	CYQ2 (April-June)	132	277	79	163	82	733
Randolph	CYQ3 (July-Sept)	75	259	66	132	63	595
Rutland	CYQ1 (Jan-March)	87	462	18	247	22	836
Rutland	CYQ2 (April-June)	79	454	18	258	15	824
Rutland	CYQ3 (July-Sept)	86	478	13	240	29	846
Springfield	CYQ1 (Jan-March)	54	106	87	114	40	401
Springfield	CYQ2 (April-June)	33	87	44	78	28	270
Springfield	CYQ3 (July-Sept)	38	75	64	83	29	289
St. Albans	CYQ1 (Jan-March)	347	759	0	610	362	2078
St. Albans	CYQ2 (April-June)	295	559	0	549	352	1755
St. Albans	CYQ3 (July-Sept)	306	531	0	518	300	1655
St. Johnsbury	CYQ1 (Jan-March)	453	769	0	1025	793	3040
St. Johnsbury	CYQ2 (April-June)	653	780	0	1348	547	3328
St. Johnsbury	CYQ3 (July-Sept)	626	819	0	1205	514	3164
Windsor	CYQ1 (Jan-March)	144	224	0	399	343	1110
Windsor	CYQ2 (April-June)	81	151	0	228	144	604
Windsor	CYQ3 (July-Sept)	149	153	0	492	82	876

Blueprint CHT Patient Counts By Payer By Health Service Area
Calendar Year 2025 Q1–Q3



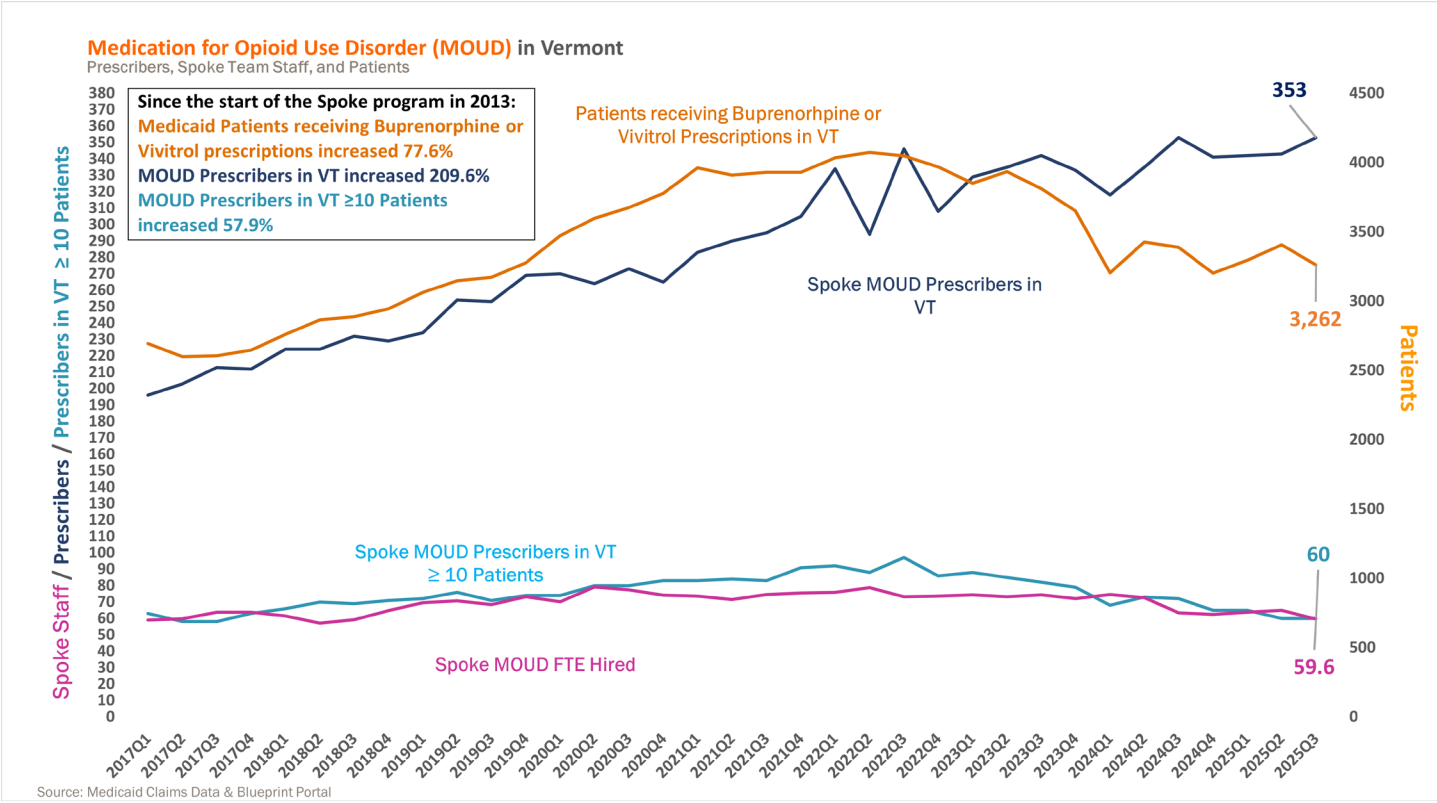
D. Hub & Spoke

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 2024 through July 2025, included eleven virtual monthly webinars and workshops and an in-person conference. Five webinars featured nationally recognized presenters on innovative, patient-centered topics such as prescription digital therapeutics, culturally responsive care, and integration of traditional medicine into care. Six virtual workshops featured Vermont experts who provide primary care based mental health and substance use care, substance use treatment during pregnancy, support for patients experiencing gender-based violence, or oral health care in the context of substance use. An average of 77 Vermont care-team members and affiliated service providers attended each virtual event. There were 141 attendees to the Community Collaboration for Mental Health & Substance Use Disorder Treatment & Recovery conference with every Health Service Area represented by between four to 37 Vermont professionals. The Director of the Center for Substance Abuse Treatment at the Substance Use and Mental Health Services Administration provided a national perspective on challenges and approaches to care with state system administrators extending the review to the Vermont context. Other presentations modeled collaboration between agencies including emergency response, peer recovery, Emergency Department (ED), Department of Corrections, Treatment Court, and specialty and general health care providers.

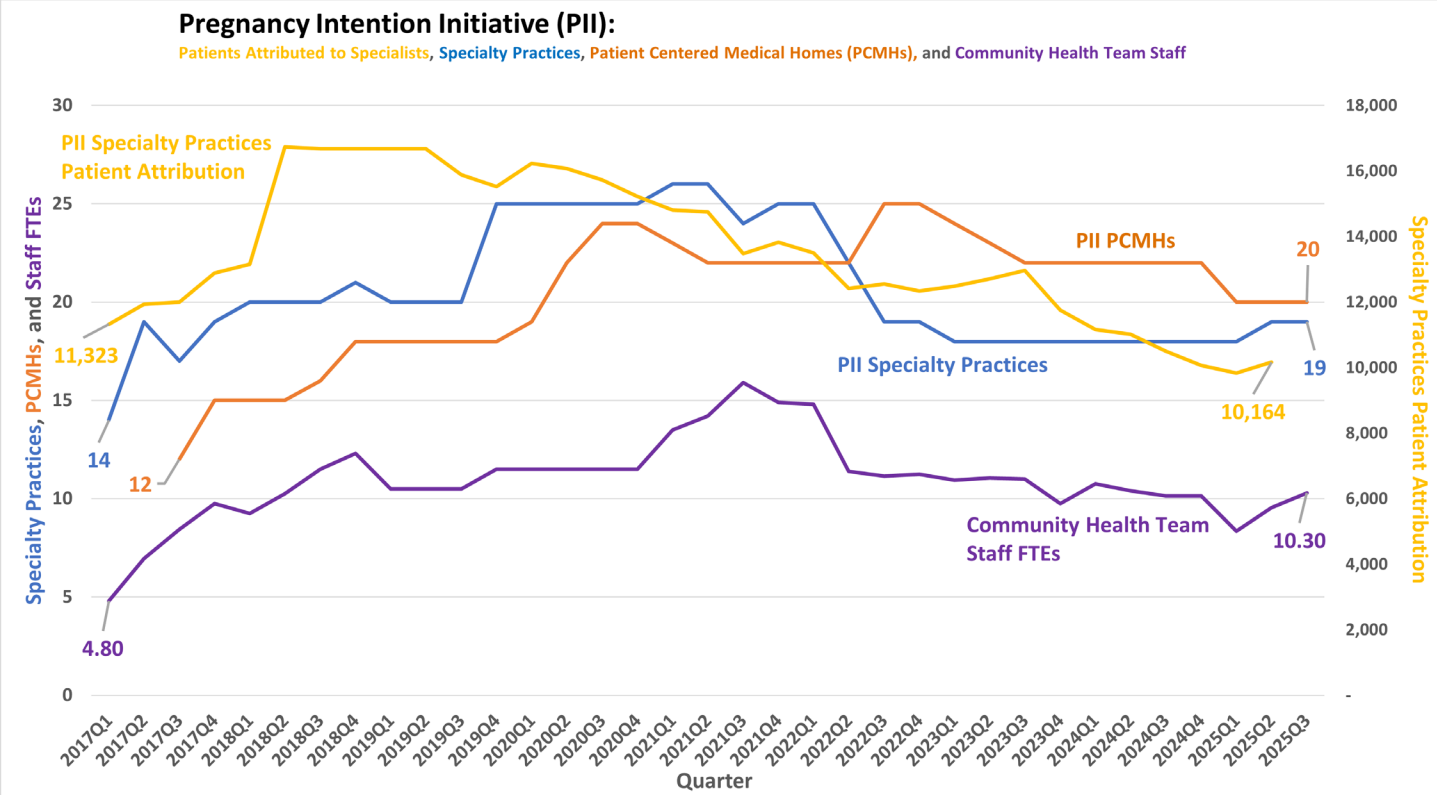
Vermont continues to demonstrate substantial access to MOUD by funding registered nurses and licensed, Master's-prepared, mental health/substance use disorder clinicians as a team. These Spoke teams offer evidence-based treatment and provide Health Home services for Vermonters with opioid use disorder. 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).



E. Pregnancy Intention Initiative (PII)

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 someone 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 both PCMH and within specialty practices. These clinicians also communicate programmatic information to community partners to build meaningful relationships and referral pathways 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 40 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 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.

In October 2024, My Healthy Vermont made significant changes to program operations to improve the participant experience, and foster increased program quality, efficiency, and cost-effectiveness. As part of the operational improvements, My Healthy Vermont developed a new "Enrollment Specialist" position, responsible for working with participants to complete registration, collect accurate data, address barriers, and ensure a positive experience. Ultimately, it is expected that the new enrollment process will better support participants, resulting in higher rates of completion.

The six types of Self-Management Programs offered during 2025 include:

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

From October 2024 through September 2025, the Department of Health and the Blueprint offered 49 workshops, with a total of 201 individuals completing a program. The Diabetes Prevention Program had the largest number 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 CHT payments. Once the agreement ends, Medicare will no longer be able to contribute payments to Blueprint programs until another agreement with CMS is signed. Vermont applied and was accepted to participate in the AHEAD model, the only available CMS agreement at the time of this report, and payments are currently expected to begin in 2028. Because of this gap between federal models, the legislature appropriated funding for Blueprint PCMHs and CHTs to cover more than $5 million in Medicare payments for CY2026. This is approximately one-quarter of the total annual funding for Blueprint practices and CHTs. The loss of this funding could result in a significant reduction in CHT staff, decreasing the availability of CHT services to Vermonters. The Blueprint is working with AHS to navigate the options to avoid a decrease in funding.

H. Performance Audit

In 2024, the State Auditor's Office (SAO) conducted a performance audit of the Vermont Blueprint for Health in collaboration with the Blueprint team. The SAO focused on the Blueprint's annual reports to the legislature and statutory requirements. The SAO report was published in February, 2025. Based on the findings from this audit, Blueprint has implemented changes to the annual report to improve readability and program evaluation.

In 2025 the Blueprint undertook a strategic planning process in accordance with statute and delivered the plan to the AHS Secretary in December. Implementation of the plan will begin in 2026 with updates and progress reported on the plan's website and with updates provided regularly to the Executive Committee and, as needed, in testimony to the legislature.

IV. EVALUATION

A. Health Care Measurement Results for Blueprint Target Populations

1. Measure Calculation Overview

The Blueprint has contracted with Onpoint Health Data to calculate annual health care evaluation measures from multi-payer claims and clinical data. These measures provide insight into the outcomes of service delivery reform and programmatic initiatives in addition to offering a statewide look at several population health measures, detailed in the next sections. Additional measures can also be found in the Community Health Profiles available on the Blueprint's website.

Data Sources

Claims-based measures are calculated from the Vermont Health Care Uniform Reporting and Evaluation System (VHCURES), which is Vermont's all-payer claims database managed by the Green Mountain Care Board. All-payer claims data includes Medicare, Medicaid, and commercial insurance claims; however, self-insured plans and federal and military insurance plans are not required to submit data (some submit, some do not). The VHCURES database does not include information on uninsured individuals. Claims data is typically delayed at least one calendar year, due to the claim submission and adjudication process; the data in this report (prepared in 2025) reflects calendar year (CY) 2023.

Measures involving clinical data utilize data from Vermont Information Technology Leaders (VITL), the Vermont clinical registry. Practices participating in the Blueprint for Health agree, as part of their participation, to submit clinical data to VITL for use in calculating aggregated population measures. Not all Vermont providers submit information to VITL.

The Blueprint maintains a practice and provider database through its online web portal. This registry provides the necessary information to determine attribution to Blueprint primary care practices.

Populations of Analysis

Results are presented for two populations: the entire population of VHCURES members and that of Blueprint attributed members. This represents a multi-payer member sample, allowing for a broader statewide view and at-a-glance comparison between trends for Blueprint attributed lives and statewide trends. In 2023, the total VHCURES population represented about 529,500 individuals, approximately 81.8% percent of Vermont's estimated 2023 population [647,464 VT Legislative Joint Fiscal Office Statewide 2023 Population Estimate]. Of this group, 438,818 had medical claims, which allowed them to be included in the measurement calculations.

2. Population Counts and Demographics

The Blueprint annually reports demographic information regarding members. The CY2023 information is found in Table V.A.1 below. Measures in this table are based on counts obtained from claims data in VHCURES. ACG risk scores are derived using the John's Hopkins Adjusted Clinical Group (ACG) risk stratification methodology. Not all members will have a risk score due to a lack of sufficient claims data for some members, but more than 90% of Blueprint and Other primary care attributed lives are assigned risk scores. The risk scores are used later to adjust other measures in order to present a balanced picture of items such as expenditures.

Statewide Demographics for 2023

Patients	Total VHCURES Members (with medical claims)	Blueprint PCMH Primary Care Attributed Members	Other Primary Care Attributed Members
Population N	438,818	246,724	147,810
Avg. Age	45.9	44.7	48.3
% Female	52.21%	53.67%	54.23%
% Medicaid	30.24%	30.89%	28.91%
% Medicare	33.48%	32.12%	35.74%
% Commercial	36.28%	36.99%	35.35%
% ACG* Healthy Users	6.59%	6.79%	5.72%
% ACG* Low Risk	11.88%	13.34%	10.91%
% ACG* Moderate Risk	40.74%	45.34%	42.23%
% ACG* High Risk	17.38%	18.65%	20.04%
% ACG* Very High Risk	10.66%	10.92%	13.19%

*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.

For CY2023, measures regarding expenditures per-member-per-year, primary care visits, emergency department visits, and various measures related to chronic conditions and screenings are reported. Table V.A.2, below, shows these measures for the 2023 calendar year. Graphs showing five-year trends in Blueprint attributed member data can be found in Appendix 1 of this report.

The total expenditures given in Table V.A.2 are risk-adjusted values, not raw values (actual dollars spent). Only data for members with risk scores can be included in the calculations for these total expenditures due to the need for risk-adjustment. Risk adjustment allows for more accurate comparison between groups, as a group with a significant proportion of high-risk members would be expected to have greater total expenditure than one consisting primarily of low-risk members. With risk adjustment, it is evident that Blueprint PCMH attributed members have a lower per-member-per-year expenditure, given their relative medical needs, than members attributed to other primary care practices. Since these values are risk adjusted, they do not reflect an exact dollar amount of savings for Blueprint attributed patients, but provide evidence that the relative costs are less for Blueprint attributed patients. While this difference appears substantial, it is impossible to predict from this data whether Blueprint PCMH attributed members' expenditures would increase, or by how much, if they were to see other providers. Caution should also be used in reaching conclusions about future cost reductions or savings as past performance cannot guarantee future results.

Notable differences are seen in clinical and claims hybrid measures. The percentage of patients with hypertension who have their blood pressure in control, for example, is several points higher for Blueprint PCMH attributed lives than for other primary care attributed lives. While many measures indicate that Blueprint is achieving its clinical goals related to chronic disease management and prevention, work remains to be done to improve the rates of screening for chlamydia and investigate reasons for increased admissions for heart failure and COPD.

Statewide Measures for CY2023

Patients	Total VHCURES (Excluding Self-Insured) Members	Blueprint PCMH Primary Care Attributed Members	Other Primary Care Attributed Members
Total Expenditures Per-Member-Per-Year*	$8,491.01 ± $44.37	$8,126.80 ± $58.60	$9,325.20 ± $90.21
% members with Primary Care Visit in Year	92.2% ± 0.2%	92.4% ± 0.4%	90.3% ± 0.5%
Outpatient ED Visits per 1000 Member Years*	345.3 ± 1.7	362.0 ± 2.3	352.4 ± 2.9
Diabetes HbA1c Not in Control (>9.0) [NQF0059] Lower is better	21.8% ± 0.6%	21.8% ± 0.7%	22.0% ± 1.2%
Hypertension with Blood Pressure in Control (<140/90) [NQF0018] Higher is better	75.8% ± 0.4%	77.0% ± 0.5%	72.3% ± 0.9%
Child & Adolescent Well-Care Visits 3-21 [HEDIS] Higher is better	59.4% ± 0.3%	67.9% ± 0.4%	49.9% ± 0.7%
Asthma Medication ratio of control medication to all asthma medication of at least 0.50 [NQF1800] Higher is better	67.1% ± 1.7%	67.3% ± 2.1%	66.1% ± 3.1%
COPD & Asthma Admissions, age 40 or over, per 100,000 [NQF0275]	1.60 ± 0.1	1.96 ± 0.2	1.45 ± 0.2
Heart Failure Admissions per 100,000 [PQI08, NQF0277]	3.1 ± 0.2	3.6 ± 0.3	3.2 ± 0.3
Chlamydia Screening in Women, 16-24yrs [NQF0033] Higher is better	45.3% ± 0.9%	43.5% ± 1.2%	48.9% ± 1.5%

*Measure is risk-adjusted using ACG scores

B. Expenditures for the period

1. Blueprint Expenditures

Blueprint for Health Annual Budget by Program Elements and Funding Source

Blueprint Program Elements	Annualized Budget for 2025	Description	Money Flow	Participation
Patient-Centered Medical Home (PCMH) Payments	$11,923,167	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)	$9,855,582	Teams support PCMH practices and interface with community services	From Payers to Local Hospital (or FQHC)	All Payers (Includes Medicare)
MHI Pilot CHT Staff	$5,256,513.93	Embedded MH/SUD and SDOH support for PCMH practices	From Payers to local FQHC or Hospital	Medicaid - Pilot funding
DULCE Family Specialists	$239,760.00	Embedded Family Specialists following the DULCE model in six pediatric practices	From Payer to local FQHC or Hospital	Medicaid - Pilot funding
DULCE Administrative Funding for VDH	$107,364.35	Memorandum of Understanding with the Department of Health	Administrative costs	DVHA/Medicaid - Pilot funding
Spoke Staff (Extended CHT)*	$5,956,406.25	RN and Mental Health Counselor teams support MOUD prescribers	From Payer to Local Hospital (or FQHC)	DVHA/Medicaid
PII PMPM Payment to Specialty Practices	$128,903.33^	Attestation to program elements	From Payer to Practices	DVHA/Medicaid
PII PMPM Payment to PCMH Practices	$53,113.33^	Attestation to program elements	From Payer to Practices	DVHA/Medicaid
PII One-Time Practice Payments	$12,517	Workflow changes for screening, same-day long-acting reversable contraception	From Payer to Practices	DVHA/Medicaid
PII Staffing (Extended CHT)	$730,699	Staff for brief interventions and navigation to services	From Payer to Local Hospital (or FQHC)	DVHA/Medicaid
PII Program Management	$22,700	Program Administration, staff supervision, Travel and training	Grant to PPNNE	DVHA/Medicaid
Program Management	$1,547,900	Change management and program administration	Grant to Local Hospital (or FQHC)	DVHA/Medicaid
Quality Improvement Facilitators	$1,120,000	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	$24,984	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

Blueprint Program Elements	Annualized Budget for 2025	Description	Money Flow	Participation
Training Contracts/ Grant(s)	$20,000	PII Trainings by UVM Faculty	Contracts with Vendors	DVHA/Medicaid
	$184,983	Dartmouth Spoke Provider Trainings		VDH
	$100,000	Center for Health and Learning		Medicaid - Pilot Funding
	$2,400	Pride Center of Vermont		Medicaid - Pilot Funding
	$17,500	Bridges Out of Poverty		Medicaid - Pilot Funding
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	$260,531	Survey of Vermonters served in primary care in accordance with statute	Contract with Vendor	DVHA/Medicaid
Qualitative Analysis of CHT MHI Pilot	$73,733	Program evaluation for CHT MHI Pilot	Contract with Vendor	Medicaid - Pilot Funding
Quantitative Analysis of CHT MHI Pilot	$283,760	Program evaluation for CHT MHI 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. Patient Experience 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 provide the broadest statewide look at patient experience of primary care in Vermont. The number of practices that participated in the 2024 survey was 122, the same number of practices that participated in 2023. A total of 73,927 surveys were distributed with 10,540 adult and 2,054 pediatric patients providing responses. The combined response rate was 17.0%, nearly identical to the 2023 response rate of 17.6%. The 2024 survey had the largest number of pediatric and adult 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 2025 to address the ongoing needs of their communities. The following section of the report includes information provided by each HSA.

Blueprint Leadership Gathering October 21, 2025 at the Waterbury State Office Complex

BARRE HEALTH SERVICE AREA

Administrative Entity: University of Vermont Health/Central Vermont Medical Center

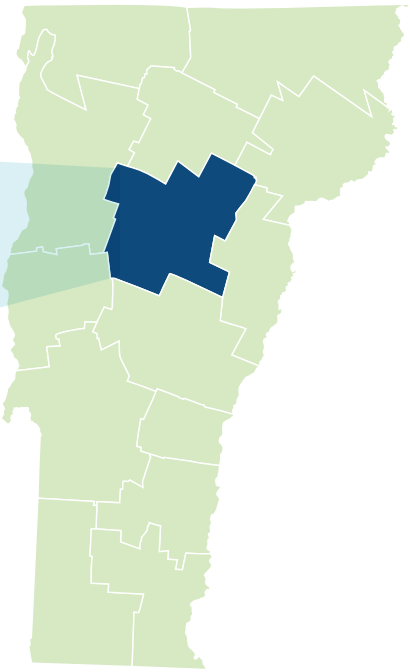
Program Manager: Constance Gavin

At a Glance

- Health Service Area Total Population
- Blueprint Practices Patient Attribution
- Community Health Team Patient Count*
- Spoke-Eligible Patient Population‡
- Community Health Team Staff FTE
- Spoke staff FTE
- Pregnancy Intention Initiative Staff FTE

* Community Health Team Patient Count (January–September, 2025—may include duplicates)
‡ Spoke Eligible Patient Population (Average July–September, 2025)

THE University of Vermont HEALTH NETWORK
Central Vermont Medical Center



COMMUNITY PARTNER ENGAGEMENT THROUGH TEAM-BASED CARE AND OTHER ACCOMPLISHMENTS

Health Care Transformation

Barre Health Service Area (HSA)'s Program Manager has served as a leader on the Agency of Human Services (AHS) Healthcare Transformation Leadership Team for the Central Region. This role is focused on relationship development and coordination with Central Vermont Medical Center (CVMC), Copley Hospital, and Gifford Medical Center, focusing on clarifying objectives, securing executive buy-in, and establishing shared goals for the region.

Team-Based Care

In 2025, the Barre HSA strengthened its commitment to team-based care and cross-sector collaboration, through the Vermont Team-Based Care (VTBC) initiative led by a Change Team. A key outcome was a shared ecosystem map and comprehensive guide to state and federally funded case management programs outlining eligibility and contract holders in the region. An initiative milestone was the definition of the "lead" case manager role, aimed at improving accountability and communication across agencies. The HSA established an aspirational community-level goal to ensure that individuals with two or more case managers are supported by a shared care plan. To support this effort, an initial draft of a shared care plan template was developed and circulated. The Change Team agreed to transition ongoing implementation activities to the Local Interagency Team (LIT) meetings led by the AHS Field Director for next steps for sustained progress.

Community Health Team (CHT)

The CHT staff have maintained their focus on connecting patients to community resources, offering brief interventions for mental health and substance use disorders, and providing robust care management for individuals with complex medical and social needs. These services have been critical in bridging gaps between clinical care and social support, ensuring that patients receive holistic, person-centered care. Barre HSA continues to deliver excellence through the Spoke program, by providing integrated care and support for individuals receiving medication for opioid use disorder. Spoke teams, embedded in practices across the region, provide counseling, care coordination, and connections to recovery resources—helping patients stabilize and thrive. The Pregnancy Intention Initiative (PII) has broadened access to reproductive health services, offering same-day contraception, screenings and counseling. Practices have strengthened screening for mental health, trauma, and social

needs, ensuring timely, respectful, and goal-aligned care across the life span.

Community Collaborative Accomplishments

In 2025, the THRIVE Accountable Community for Health (ACH) made several outstanding achievements aligned with its mission is to optimize the health and wellbeing of our community. THRIVE was recognized at the 2025 Vermont Public Health Association for their leadership in the 2024 Central Vermont Flood Response. THRIVE was selected to host a panel presentation at the UVM Health Network Health Equity Summit to represent the collaborative's Community Preparedness and Response work spotlighting the focus on rural health and climate impacts to social drivers of health. THRIVE partnered with CVMC to conduct the Community Health Needs Assessment (CHNA) and develop the Community Health Improvement Plan (CHIP) which will serve as the focus for THRIVE's work.

MyHealthyVT Outreach

The MyHealthyVT (MHVT) Provider Outreach Specialist completed targeted outreach to primary care practices and Veterans Affairs in Central Vermont including Barre and Randolph HSAs. She represented MHVT at community events and delivered workshops to diverse groups including healthcare providers, community organizations, and employers. She ensured timely participant reporting to the Vermont Department of Health (VDH) and strengthened program efficiency.

"Compassion and care during every phone conversation. She also sent messages via MyChart of list of therapists and also follow up."

—CHT Patient in the Barre HSA

QUALITY IMPROVEMENT (QI) ACHIEVEMENTS

HSA Data-Driven Quality Improvement

UVM Health-CVMC practices rely on granular and dynamic data sources to guide the identification of quality improvement opportunities including our High Value Care (HVC) Priority Measure Dashboard. For the two independent practices, one a Federally Qualified Health Center (FQHC) and the other a Naturopathic practice, the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey has been an essential tool in helping the practices meet their Patient-Centered Medical Home (PCMH) requirements.

Practice Quality Achievements

Expanding Depression Screening beyond Preventive Visits at CVMC Practices

- Used HVC Priority Measure Dashboard to determine performance improvement opportunity
  - Successfully screening at 80% preventive visits, but only 59% of established patient visits.
  - Preventive visits only account for 23% of screening opportunities
  - Need to screen outside of preventive visits to meet target (70%)
- Baseline (CY2024): 57.5%, Current Performance (through Oct 2025): 69.7%

"I'm honored to work alongside our community partners to reimagine team-based care and lead meaningful healthcare transformation. Together, we're not just improving systems—we're building a stronger, more connected future that addresses social drivers of health. Through Blueprint-supported initiatives, the Barre Health Service Area is shaping a responsive collaborative system that rises to challenges and delivers on the promise of a healthier community."

—Blueprint Program Manager in the Barre HSA

FUTURE GOALS

Chronic Disease Management

The Barre HSA integrates the PCMH model with Blueprint CHTs to deliver team-based, comprehensive, and coordinated care. This approach emphasizes data-driven, evidence-based, patient-focused strategies to improve outcomes and experience, particularly for individuals managing chronic conditions such as diabetes, hypertension, and Chronic Obstructive Pulmonary Disease (COPD).

Reducing Deaths by Overdose and Suicide

Barre HSA initiatives align with statewide goals to reduce preventable deaths and improve mental health outcomes by addressing suicide and overdose through multiple strategies. These include provider education and awareness using the ZeroSuicide model, embedding mental health professionals in primary care, and expanding counseling access and targeted screening for suicide risk, anxiety, and depression through the Blueprint Mental Health Integration (MHI) pilot. The HSA also actively participates in the Hub & Spoke model, supporting individuals with opioid use disorder through Medication for Opioid Use Disorder (MOUD) and wraparound services. Central Vermont Prevention Coalition serves as the community convenor and networking body to remove siloed care between the medical community and substance use treatment providers.

Improving Access to Primary and Specialty Care

Blueprint-funded staff in the Barre HSA serve as navigators and resource coordinators, linking patients to primary care, specialists, and social services. This collaborative approach reduces barriers and equips patients with strategies to ensure timely access to essential health services.

PATIENT EXPERIENCE AND IMPACT

In the four-month post The UVM Health Integrated Care Management conducted patient experience follow up surveys, anonymous patient surveys yielded 350 responses (17%+ response rate). Results showed satisfaction scores exceeding 90%, themes underscore the value of care managers in building longitudinal relationships, fostering rapport, and listening nonjudgmentally—all critical to patient trust and engagement.

> "He answered all of my questions in his words so that I would understand him. I enjoyed him very much."
>
> —CHT Patient in the Barre HSA

> "I've been able to support pregnant and postpartum patients, including those receiving MOUD treatment, by connecting them to essential services. Recently, I've helped patients navigate the closure of Better Life Partners and transition care from Lamoille County and Copley Hospital."
>
> —CHT Staff in the Barre HSA

> "Our patient needed to be connected to services to help detox from alcohol use disorder prior to a surgery. The program allowed us to formulate a plan with the surgeon, ED and community partners, identify resources and provide options for the patients."
>
> —MHI Staff in the Barre HSA

BENNINGTON HEALTH SERVICE AREA

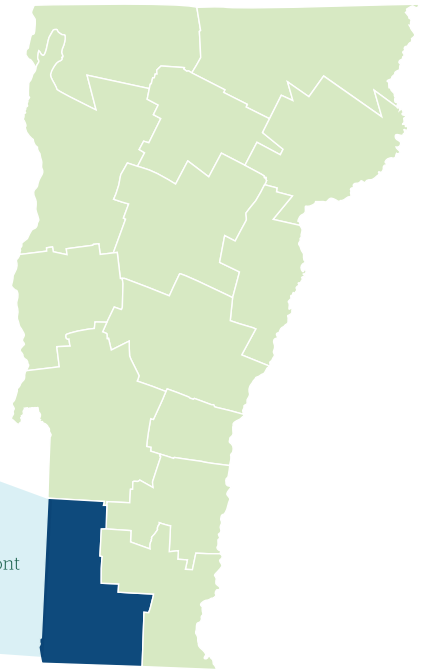
Administrative Entity: Dartmouth Health/Southwestern Vermont Medical Center

Program Manager: Todd Salvesvold

At a Glance

28,330	Health Service Area Total Population
15,423	Blueprint Practices Patient Attribution
4,497	Community Health Team Patient Count*
328	Spoke-Eligible Patient Population‡
15.7	Community Health Team Staff FTE
6.5	Spoke staff FTE
1.1	Pregnancy Intention Initiative Staff FTE

* Community Health Team Patient Count (January–September, 2025—may include duplicates)
‡ Spoke Eligible Patient Population (Average July–September, 2025)



Dartmouth Health Southwestern Vermont Medical Center

COMMUNITY PARTNER ENGAGEMENT THROUGH TEAM-BASED CARE AND OTHER ACCOMPLISHMENTS

In 2025, Blueprint played a major role in the development of the First Steps Program (FSP), a comprehensive alcohol-use disorder (AUD) treatment program that serves the Bennington Health Service Area (HSA). Supported by Southwestern Vermont Medical Center (SVMC), the Turning Point Center of Bennington (TCP), United Counseling Service (UCS) and Blueprint, the FSP is designed to support people throughout the course of their recovery. As people in need of recovery services are identified, members of the Blueprint team or Peer Recovery Coaches from TCP outreach the patient to discuss treatment options. If agreeable, the patient is navigated to the SVMC Emergency Department whereby medical clearance is established to ensure the patient entering detox or rehabilitation is able to transition to the inpatient environment. Once the immediate health needs have been addressed, members of the SVMC Case Management team in partnership with the Blueprint RN seek to establish a long-term recovery plan with the patient, which may involve a transfer to an AUD rehabilitation facility or outpatient treatment provider.

Our Health Service Area (HSA) regularly participates in several other initiatives that demonstrate strong partnerships within the community. For example,

> "It has been amazing working for Blueprint. This is really the first job I can remember where I had an immediate impact on a person's well-being. Having the ability to meet with people, identify the barriers to their health and work on solutions gives me a great deal of satisfaction. I am not sure where many of these patients would be without Blueprint."
>
> —Blueprint Community Health Navigator (Mental Health Integration)

Blueprint is an active member if Project Alliance (PA), a community-wide consortium made up of local non-profits such as UCS, and Bennington Rescue, as well a public safety partners, such as the Bennington Police Department and Bennington Sheriff's office. PA is a multi-faceted effort within the HSA that addresses community-wide challenges such as substance abuse and public safety by coordinating resources and services effectively. In addition, Blueprint is also a very active member of The Situation Table, another multi-agency model designed to address people or families who are considered to be at significant risk for things like homelessness, substance use, mental

health crises, or public safety issues. Like PA, this group brings together local law enforcement, public health and behavioral health services, but also involved agencies such as Bennington Coalition for the Homeless and The Green Mountain Express that support housing and transportation respectively.

"I have been with Blueprint for many years now, and can say without a doubt that many of the people I work with would have slipped in their recovery without Spoke case management and therapy, especially having it located under the same roof where they receive Medication for Opioid Use Disorder(MOUD). So many of these people have major social determinant of health needs that it would be almost impossible for them to maintain sobriety without someone in their corner."

—Spoke RN

"I've been going to your office for a couple of years and wanted to call offer my thanks for your employee Rhonda Harman. I have developed some major health issues and she has done so much to help me manage it all. She schedules all the medical cab rides and goes over my medications and has been such a huge help to me. I have so many different things going on with my health I don't know what I would do without her; she has just been beyond great. "

—Patient working with a Blueprint RN

QUALITY IMPROVEMENT (QI) ACHIEVEMENTS

HSA Data-Driven Quality Improvement

In the Bennington HSA, the use of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) results has been instrumental in identifying patterns and trends related to patient satisfaction and care delivery. By systematically reviewing CAHPS survey data, the HSA was able to pinpoint specific areas such as communication with providers, access to care, and responsiveness of office staff that consistently influenced overall patient experience scores. These insights enabled the team to uncover root causes of patient concerns, such as delays in appointment scheduling or gaps in provider-patient communication, and to develop targeted interventions aimed at addressing these key issues. As a result, the data not only guided quality improvement priorities but also fostered a culture of continuous feedback and responsive action within the HSA.

Similarly, the utilization of practice profiles has played a critical role in enhancing both HSA-wide and clinic-specific quality metrics. These profiles not only facilitated comprehensive data comparisons across the HSA but also empowered individual clinics to monitor their progress over time. By reviewing these measures longitudinally, clinics were able to celebrate areas of success and proactively address gaps, fostering a culture of continuous improvement. The practice profiles encouraged clinics to ask deeper questions and investigate the root causes behind their performance, which ultimately led to more targeted and effective quality improvement initiatives.

Measure results have directly influenced enhancements in Electronic Medical Record (EMR) data collection by highlighting areas where documentation practices needed refinement. For example, when CAHPS survey data revealed inconsistencies in reported patient-provider communication, practices responded by updating EMR templates to prompt more thorough and standardized documentation of patient interactions. This not only improved the accuracy and completeness of the data captured but also ensured that critical information relevant to quality

measures was consistently recorded. These changes, driven by the measure results, have enabled more reliable reporting and better-informed quality improvement efforts across the HSA.

Practice Quality Achievements

Over the past year, targeted quality improvement efforts at Bennington HSA have led to better appointment access, higher CAHPS communication scores, and enhanced EMR documentation. Metrics show shorter wait times, improved scheduling, and better provider-patient interactions. Both quantitative data and patient feedback confirm increased satisfaction, demonstrating a positive impact of these initiatives. In addition, there has been a concentrated effort in the Health Service Area to strengthen the depression screening process in the practices, with a particular focus on increasing the practice screening rate.

Details of this quality initiative are below:

- **Context and Rationale**: In reviewing patient care processes, several Blueprint practices identified gaps in the timely screening and follow-up management of depression. Patient feedback and internal survey data indicated that mental health concerns were sometimes missed or inadequately addressed during routine visits, prompting the need for a more systematic approach.
- **Baseline Data**: For one practice (though this particular measure has been of high focus at all Bennington clinics) at the start of the initiative, only 62% of eligible patients received documented depression screening during annual visits, and follow-up rates for those who screened positive were below 40%.
- **Changes Tested and Implemented:** The practice provided re-training with workflow depression screening tools within the EMR and developed prompts for providers to ensure follow-up plans were documented for patients with positive screens. Staff received targeted training on the importance of mental health assessment and effective communication strategies.
- **Results and Outcomes**: Within one year, depression screening rates increased to 88%, and documented follow-up for positive screens rose to 75%. Providers reported greater confidence in addressing mental health needs, and patient satisfaction scores related to emotional support improved. We believe this improvement in mental health support is also coupled with the pilot program that the blueprint implemented.

FUTURE GOALS

With the launch of a Hub in Bennington, a level of care that has been absent from the service area, discussions have started with the various Spokes in the HSA to identify patients that have not been successful with other forms of treatment and may benefit from methadone. Utilizing local initiation and engagement data, this effort will attempt to identify patients that have a history of incomplete treatment episodes, or have a history of overdosing despite engagement in treatment. Once identified, a workflow for transition between the various levels of care will be established, which is expected to include specifics on the role of the Spoke Registered Nurse (RN.)

BRATTLEBORO HEALTH SERVICE AREA

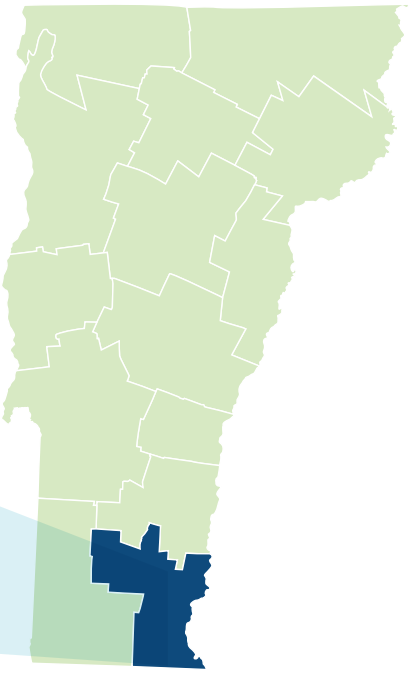
Administrative Entity: Brattleboro Memorial Hospital

Program Manager: Rebecca Burns

At a Glance

23,240	Health Service Area Total Population
14,041	Blueprint Practices Patient Attribution
3,401	Community Health Team Patient Count*
441	Spoke-Eligible Patient Population‡
9.95	Community Health Team Staff FTE
2.2	Spoke staff FTE
.5	Pregnancy Intention Initiative Staff FTE

* Community Health Team Patient Count (January–September, 2025—may include duplicates)
‡ Spoke Eligible Patient Population (Average July–September, 2025)



Brattleboro Memorial Hospital
EXCEPTIONAL CARE FOR OUR COMMUNITY

COMMUNITY PARTNER ENGAGEMENT THROUGH TEAM-BASED CARE AND OTHER ACCOMPLISHMENTS

In 2025, our Health Service Area (HSA) strengthened collaboration across the continuum of care through application of the Team-Based Care (TBC) model. Monthly meetings provided a structured forum for sharing resources, aligning workflows, and coordinating care among hospitals, independent practices, and community partners.

To support consistency and quality, we implemented standardized care coordination and care management training developed with the Camden Coalition. Participants included Support and Services at Home (SASH), primary care coordinators, designated mental health agencies, Area Agencies on Aging, nursing homes, Brattleboro Memorial Hospital (BMH) inpatient care managers, Vermont Chronic Care Initiative (VCCI) nurses, and emergency medical services (EMS) providers. A steering committee, led by the Blueprint Program Manager (PM) and Agency of Human Services (AHS) District Director, guides planning and collaboration across health and human service sectors.

Several initiatives exemplify effective TBC. Mental Health Integration (MHI) staff provide brief interventions in primary care, expanding access to mental health support and strengthening in-office collaboration. The Pregnancy Intention Initiative (PII) increased same-day access to long-acting reversible contraception (LARC) while addressing patients' social and mental health needs in OB/GYN settings, improving experience and outcomes.

Strong partnerships with designated agencies, home health and hospice, and SASH nurses have enhanced warm handoffs and care transitions. The Mobile Integrated Health program—partnering BMH, Rescue Inc., and BMH primary care—delivers in-home, team-based care for high-risk patients, providing care coordination, chronic disease management, preventive care, and referrals for health-related social needs (HRSN). Collectively, these efforts advanced coordinated, community- based care across the HSA.

> "Vermont is rural state, and many residents face barriers to healthcare access. Blueprint staff help overcome these challenges."
>
> —Blueprint Care Coordinator

QUALITY IMPROVEMENT (QI) ACHIEVEMENTS

Blueprint data has been central to identifying needs, guiding investments, and strengthening care delivery in Windham County. Patient experience survey data over the last two years shows that Brattleboro HSA performs exceptionally in the Mental Health Access domain, outperforming all other HSAs in both the "always" composite score and mean composite score in consumer assessment surveys.

At the same time, statewide data highlighted the significant behavioral health needs in Windham County, including high fatal and nonfatal overdose rates and the highest rate of suicide-related emergency department visits in Vermont. These data informed local planning, staffing, and funding priorities. In response, the HSA maintained a strong Mental Health Integration (MHI) workforce in 2025, including four social workers and one community health worker embedded in primary care, ensuring access to brief interventions, care coordination, and warm handoffs.

Practice Quality Achievements

Primary care teams also improved clinical quality measures in 2025. Brattleboro Primary Care increased depression screening rates by over 25 percentage points for more than 1,800 patients aged 12 and older, achieving a 90% rate of documented follow-up for positive screenings. The Blueprint-funded registered dietitian nutritionist (and certified diabetes care and education specialist) at Grace Cottage Family Health advanced glycemic control by integrating continuous glucose monitor (CGM) data into medical records, training staff to download and input patient data, and supporting patients in troubleshooting devices.

FUTURE GOALS

In 2026, our HSA aims to recruit additional practices to become Patient-Centered Medical Homes (PCMHs) and leverage HSA-wide data to support a shared goal: improving patient health through enhanced chronic disease management, expanded access to mental health services, and increased availability of primary care.

"While many people may think about engaging in mental health support, having a mental health clinician available through their primary care office reduces the time, energy, and challenges involved in searching for a therapist in the community. Time and time again, referrals are made by PCPs to connect individuals with care weeks or months before they access care in the community. This early and quick connection to care allows for a more preventative approach; people get support before stress or challenges escalate to larger concerns and problems."

—Integrated Mental Health Clinician

"Blueprint nurses give people a voice who wouldn't otherwise have one and would experience challenges in navigating the healthcare system."

—Blueprint QI Facilitator

BURLINGTON HEALTH SERVICE AREA

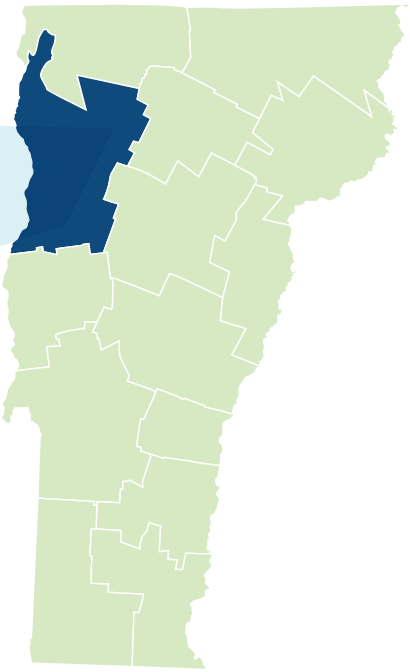
Administrative Entity: University of Vermont Medical Center

Program Manager: Michelle Farnsworth

At a Glance

118,095	Health Service Area Total Population
89,573	Blueprint Practices Patient Attribution
35,060	Community Health Team Patient Count*
698	Spoke-Eligible Patient Population‡
65.64	Community Health Team Staff FTE
14	Spoke staff FTE
2.5	Pregnancy Intention Initiative Staff FTE

* Community Health Team Patient Count (January–September, 2025—may include duplicates)
‡ Spoke Eligible Patient Population (Average July–September, 2025)



COMMUNITY PARTNER ENGAGEMENT THROUGH TEAM-BASED CARE AND OTHER ACCOMPLISHMENTS

In 2025, the Health Service Area (HSA) strengthened its commitment to team-based care (TBC) and cross-sector collaboration, resulting in meaningful improvements in care coordination and patient experience. Through the leadership of Blueprint for Health Field Staff, we've deepened partnerships across hospital settings (including UVM Medical Center [UVMMC]), independent practices, and our Federally Qualified Health Center (FQHC), Community Health Center.

The CHT staff have maintained their focus on connecting patients to community resources, offering brief interventions for mental health and substance use disorders, and providing robust care management for individuals with complex medical and social needs. These services have been critical in bridging gaps between clinical care and social supports, ensuring that patients receive holistic, person-centered care. The Burlington HSA also has seen continued success through the Spoke program, which provides integrated care and support for individuals receiving medication-assisted treatment for opioid use disorder. Spoke teams, embedded in practices across the region, offer counseling, care coordination, and connection to recovery resources, helping patients stabilize and thrive. Additionally, the Pregnancy Intention Initiative (PII) has expanded access to reproductive health services, including same-day contraception and comprehensive counseling. Practices have enhanced screening for mental health and social needs, ensuring that individuals receive timely, respectful, and informed care aligned with their goals. These initiatives reflect our ongoing commitment to equity, access, and whole-person care across the lifespan.

As our local landscape continues to evolve, we are fortunate to have several well-established and active forums that foster meaningful cross-sector engagement throughout the Burlington HSA. Collaboratives such as the Adult Local Interagency Team (Adult LIT) and the Children's Local Interagency Team (Children's LIT) provide essential spaces for agencies to coordinate services for individuals with complex needs, whether adults or youth, and help strengthen the local System of Care. In addition, the Situation Table offers a rapid-response model for addressing situations of acutely elevated risk, ensuring timely and coordinated support for individuals in crisis. Additionally, the Chittenden Accountable Community for Health (CACH) has emerged as a vital cross-sector

collaborative focused on improving the health and well-being of all who live and work in Chittenden and Grand Isle Counties. CACH centers its work around the top health priorities identified in the Community Health Needs Assessment—building community connectedness, engaging mental health, and increasing access to care—while aligning efforts across sectors and elevating community voices. These coalitions reflect the depth of collaboration in our region and continue to play a vital role in improving outcomes and building a more connected, responsive health ecosystem.

In parallel, the MyHealthyVT (MHVT) Program has made significant strides in enhancing provider engagement and improving referral processes. The MHVT Provider Outreach Specialist has worked closely with primary care practices across both the Burlington and Middlebury HSAs, using newsletters, presentations, and individualized support to raise awareness and build capacity. Despite the ongoing challenge of limited provider availability, interest in MHVT programming has grown steadily through word-of-mouth and targeted outreach. To streamline workflows and make referrals more accessible, smart phrases have been promoted for University of Vermont Health (UVMH) providers, and template phrases have been distributed to independent practices. These efforts have helped ensure that patients can reliably access MHVT programs, further strengthening the continuum of care.

Together, these initiatives reflect a coordinated, community-driven approach to improving health outcomes and patient experience across the Burlington HSA.

QUALITY IMPROVEMENT (QI) ACHIEVEMENTS

HSA Data-Driven Quality Improvement

QI Facilitators supporting independent practices in the Burlington HSA analyzed two years (2023–2024) of aggregate data from twenty-two practices' electronic health records (EHRs) to identify trends and performance outcomes. This analysis revealed that depression and hypertension were common areas for improvement across the majority of practices. Notably, 74% of eligible practices implemented QI activities aligned with Patient-Centered Medical Home (PCMH) submission requirements.

UVMMC practices rely on more granular and dynamic data sources to guide the identification of QI opportunities including the UVM Health High Value Care (HVC) Priority Measure Dashboard.

Community Health Centers (CHC) uses data-driven strategies and community health workers (CHW) to proactively reach out to patients needing depression, diabetes, cervical cancer, hypertension, or medication-management follow-up, addressing Social Drivers of Health (SDOH) and supporting appointment completion. In early 2025, CHC evaluated performance against goals and implemented targeted improvement plans across multiple measures, supported by QI facilitation for upcoming PCMH reporting.

Improving data collection/quality and/or data integration activities

The review of Blueprint-related data sets highlighted inconsistencies in how data was collected and entered into Electronic Health Record (EHR) systems. These findings prompted practices to test and revise workflows to improve data accuracy and consistency. These changes have supported better data integration and review processes.

Targeted process/clinical QI initiatives

Over the two-year period, targeted clinical and process improvement strategies led to measurable improvements in care delivery. Key initiatives included:

- Identifying patients overdue for preventive and chronic care services.
- Providing nurse education on accurate blood pressure (BP) measurement techniques.
- Promoting the use of home BP monitoring, including patient education and collaboration with pharmacies to ensure Medicaid beneficiaries received prescriptions for free BP monitors.

Practice Quality Achievements

Enhancing ADHD Medication Adherence Through Parent Engagement: A pediatric practice observed that parents were frequently reluctant to bring their children in for required follow-up visits related to

ADHD medication management, resulting in gaps in care and non-compliance with evidence-based guidelines. The practice introduced an ADHD Medication Contract for parents, outlining their agreement to adhere to the treatment plan, including scheduled follow-up visits. Since implementation, parent adherence to the contract has significantly improved. Patients are now being seen in a timely manner, aligning with clinical guidelines and enhancing overall medication compliance.

UVMMC's QI Facilitator identified an opportunity to improve performance using the High Value Care (HVC) Priority Measure Dashboard. At baseline (CY2024), overall depression screening rates were 65.5%. Analysis revealed that 82% of patients were screened during preventive visits, while only 60% were screened outside of preventive visits, even though preventive visits account for just 25% of all screening opportunities. To meet the target of 70%, it was essential to expand screening beyond preventive visits. As of October 2025, current performance has reached 72.8%.

FUTURE GOALS

The Burlington HSA, led by the UVMMC, plays a pivotal role in furthering the Vermont Blueprint for Health's mission to improve population health, enhance patient experience, and reduce healthcare costs. Through a coordinated, data-driven, and community-based approach, Burlington HSA is making meaningful strides in three critical areas:

1. Chronic Disease Management

The Burlington HSA integrates the PCMH model with multidisciplinary Community Health Teams (CHT) to deliver comprehensive, whole-person care. These teams include nurses, social workers, behavioral health specialists, and care coordinators who work collaboratively to support patients with chronic conditions such as diabetes, hypertension, and Chronic Obstructive Pulmonary Disease (COPD). By leveraging clinical data, practices in the Burlington HSA are able to identify gaps in care and target intervention—such as referring patients to self-management programs, collaborating with care teams on shared care plans, and ensuring that high-risk individuals receive intensive care coordination—which supports improved patient outcomes like A1c control and medication adherence.

"Sometimes parents come in feeling overwhelmed, unsure where to start, and struggling to find a therapist. I may not be the perfect long-term fit for every family, but I can be a warm place to land—a safe and welcoming introduction to what therapy can be. With Blueprint's support, I'm able to offer short-term care that helps normalize the experience of seeking mental health support. Often, I serve as a "starter therapist," helping families understand what therapy is, feel comfortable with the process, and get connected to someone who specializes in their specific needs. It's about opening the door to other kinds of care and making that first step feel less intimidating."

—MHI-funded Clinician

2. Reducing Deaths by Overdose and Suicide

The Burlington HSA actively participates in the Blueprint's Hub & Spoke model, which supports individuals with opioid use disorder through medication-assisted treatment and wraparound services. Spokes in both primary care and specialty settings offer ongoing support and behavioral health services. Suicide prevention efforts have been bolstered by embedding mental health professionals within primary care practices and expanding access to counseling services through the Blueprint's Mental Health Integration (MHI) Pilot. These efforts are aligned with statewide goals to reduce preventable deaths and improve behavioral health outcomes.

"A young client and her mother felt a deep sense of relief after receiving a specific and treatable mental health-related diagnosis. For them, having a name for what was happening brought clarity and comfort. The distress of not understanding the "why" behind her experiences had been overwhelming. But once they had the language to describe it, they could begin to move forward. Her mom described it as "like coming out of the forest"—finally able to see a path ahead. It was a powerful reminder of how meaningful it can be to help families make sense of their experiences and begin healing in a supportive, trusted space."

—Blueprint MHI-funded Clinician

3. Improving Access to Primary and Specialty Care

Many Blueprint-funded staff in the Burlington HSA serve as navigators and resource coordinators, helping patients connect with primary care providers, specialists, and social services. Special attention is given to Medicaid members and individuals with complex needs through partnerships with the Vermont Chronic Care Initiative (VCCI), which provides intensive case management and helps patients establish medical homes. Many practices in the HSA use shared care planning tools to streamline referrals and ensure continuity of care across settings. These strategies reduce barriers to care and promote timely access to essential health services.

"She connected me with experts on managing a healthier lifestyle. She was kind and helpful. She is awesome!"

—Patient of Blueprint CHT-funded Care Coordinator

"One of my patients is an elderly woman with several chronic illnesses, no immediate family support, and a high risk for safety concerns. Her uncontrolled diabetes led to skin breakdown and ultimately to a toe amputation. Along with SASH and UVM Home, Health, & Hospice, we explored and sadly exhausted, all options for her to stay home and have in-home assistance. Collaboratively we created a plan she could agree to and she just recently toured assisted living facilities."

—Blueprint CHT-funded Social Worker

"I love being able to watch the people I work with live their lives. Whether it's getting a job they really wanted, buying a house that they never thought they could, having their family unit be reunited, going back to school, accessing health or dental care that has historically been neglected, or working through a difficult challenge while maintaining their recovery, it is really wonderful to see people out there in the world just doing their thing."

—Blueprint Spoke-funded Nurse

"Thanks to Blueprint's Mental Health Integration funding, clinicians are able to offer timely, short-term mental health support to patients aged three to 18 directly within their pediatric medical home. This model allows families to access care quickly, without the stress of navigating insurance requirements or waiting for a formal diagnosis. It creates a safe, authentic space where patients and caregivers can begin engaging with mental health services in a way that feels approachable and validating. Clinicians can have meaningful conversations about emotional challenges, parenting struggles, and developmental concerns—often serving as a bridge to longer-term therapy when needed. The high-trust environment of the medical home makes it easier to explore sensitive topics, like boundary setting or the hesitation around receiving a diagnosis. This integrated approach helps families feel supported and understood, right when they need it most."

—Blueprint MHI-funded Clinician

"When MOUD becomes part of primary care, recovery becomes part of everyday care. The MOUD team's dedication ensures Vermonters receive the support they need close to home, and with the same trusted providers they turn to for all aspects of their health."

—Blueprint Spoke-funded Nurse

"I've met individuals who have never had anyone to talk with and are opening up for the first time. Others have long histories of suicidality, substance use, childhood trauma, schizophrenia, anxiety, and depression. Several patients have been described by their primary care providers as people they've tried for years to connect with therapy, and because I am just a few doors down, those patients are willing to give it a try. This model is truly bridging a gap in care and reaching individuals who might otherwise fall through the cracks. I feel grateful and honored to be part of this work."

—MHI-funded Clinician

MIDDLEBURY HEALTH SERVICE AREA

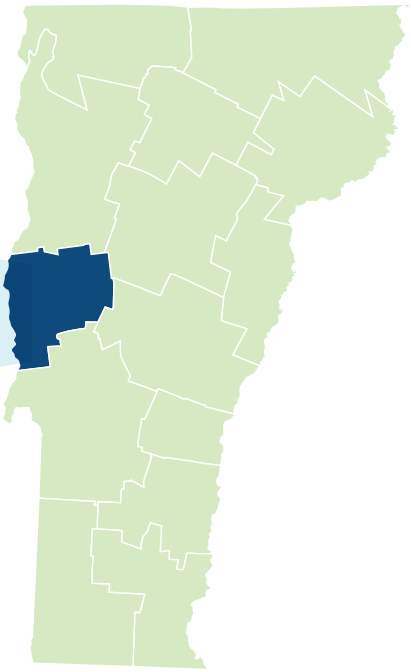
Administrative Entity: University of Vermont Health/Porter Medical Center

Program Manager: Emmy Wollenburg

At a Glance

20,018	Health Service Area Total Population
17,879	Blueprint Practices Patient Attribution
10,926	Community Health Team Patient Count*
127	Spoke-Eligible Patient Population‡
13.27	Community Health Team Staff FTE
2.5	Spoke staff FTE
.65	Pregnancy Intention Initiative Staff FTE

* Community Health Team Patient Count (January–September, 2025—may include duplicates)
‡ Spoke Eligible Patient Population (Average July–September, 2025)



COMMUNITY PARTNER ENGAGEMENT THROUGH TEAM-BASED CARE AND OTHER ACCOMPLISHMENTS

In 2025, the Middlebury Health Service Area (HSA) strengthened its commitment to team-based care and cross-sector collaboration, driving measurable improvements in care coordination and patient experience. Blueprint for Health Field Staff deepened partnerships across hospital, independent, and Federally Qualified Health Center (FQHC) settings, re-energizing relationships with key community partners through the Community Health Action Team (CHAT).

Community Collaboration and Engagement

A major achievement was the relaunch of the CHAT in Addison County. Co-facilitated by United Way of Addison County, Porter Medical Center, and Blueprint for Health, CHAT provides a structured forum for local partners to align efforts with the Community Health Improvement Plan (CHIP) and advance collaborative projects. Meetings, held every other month, emphasize connection, resource sharing, and continuous improvement, fostering stronger relationships and coordinated action across the region.

Community Health Team (CHT) staff continued to connect patients to resources, provide brief interventions for mental health and substance use, and deliver care management for individuals with complex conditions. These services bridge gaps between clinical care and social supports, ensuring holistic, person-centered care.

> "A family going through a major transition shared how grateful they were to have access to support during the process—not after. Without Blueprint's integrated care model, they likely wouldn't have received help at all. Being able to connect with a clinician in the moment, within their trusted medical home, made a meaningful difference. It allowed them to navigate the emotional challenges of change with guidance and reassurance, rather than waiting until things reached a breaking point."
>
> —Blueprint MHI-funded Clinician

The My Healthy Vermont (MHVT) program advanced provider engagement and referral processes. Outreach included newsletters, presentations, and individualized support to primary care practices across Burlington and Middlebury HSAs. Workflow

improvements, such as smart phrases for UVM Health system providers and templates for independent practices, have simplified referrals and improved patient access.

Health-Related Social Needs (HRSN) and Care Management Expansion

In January 2025, full implementation of HRSN screening launched across Middlebury primary care practices, resulting in a 25% increase in referrals to Integrated Care Management, averaging 730 referrals per month. Resource Coordinators and Community Health Workers (RC/CHWs) triage these referrals, addressing immediate social needs before longitudinal care engagement. Between March and July 2025, top referral reasons included:

- Financial Support/Economic Resources: 1,081
- Connection to Community Resources: 1,062
- Transportation: 648
- Insurance Navigation: 555
- Housing Support: 405

RC/CHWs were also trained to connect patients with non-urgent mental health needs to community-based services, screening for geography, insurance, language, and availability.

"A young woman was referred for short-term support to help manage significant anxiety—specifically around starting a medication she had been prescribed. We scheduled a joint visit with her, her primary care provider, and me. It was a powerful opportunity to talk openly about her fears, the potential side effects, and the emotional weight behind her hesitation. This kind of integrated care—where mental health and medical providers collaborate—creates a space where patients feel truly cared for. By the end of the appointment, she felt safe enough to take the medication before even leaving the clinic. She left feeling empowered, supported, and confident that she could move forward. It was a reminder of how blending mental health and medical care can make a real difference when we honor both sides of the experience."

—Blueprint MHI-funded Clinician

QUALITY IMPROVEMENT (QI) ACHIEVEMENTS

HSA Data-Driven Quality Improvement

The Middlebury HSA is made up of a mix of UVM Health, Independent, FQHC and Naturopathic practices. These practices utilize Electronic Medical Record (EMR) data and QI dashboards to track progress. The five independent practices use the Consumer Assessment of Healthcare Providers and Systems (CAHPS) results to identify areas for improvement in the patient experience and access domains. The CAHPS survey has been an essential tool in helping the practices meet their Patient-Centered Medical Home (PCMH) requirements.

Practice Quality Achievements

- Expanding Depression Screening beyond Preventive Visits at PMC Practices
  - Used High Value Care (HVC) Priority Measure Dashboard.
  - HVC Priority Measure Dashboard to determine performance improvement opportunity.
    - Successfully screening at 78.6% preventive visits, but only 52% of established patient visits.
    - Preventive visits only account for 24% of screening opportunities
    - Need to screen outside of preventive visits to meet target (70%)
  - Baseline (CY2024): 59.1%, Current Performance (through Oct 2025): 68.6%
- Increasing Well-Child Visits at Rainbow Pediatrics through outreach and changes in checkout procedures.
  - While reviewing data and discussing QI work for 2025, Rainbow Pediatrics identified well-child visits as an area of improvement that could help improve performance across other measures.
  - Practice sent out handwritten postcards to patients overdue for well visits.

- Practice scheduled well visits at checkout for patients seen for acute or follow-up visits.
- Baseline (CY2024): 65%, Current Performance (As of early November): 80%

FUTURE GOALS

Chronic Disease Management

The Middlebury HSA integrates the PCMH model with a multidisciplinary CHT to deliver comprehensive, whole-person care. The CHT include nurses, social workers, behavioral health specialists, and care coordinators who work collaboratively to support patients with chronic conditions such as diabetes, hypertension, and Chronic Obstructive Pulmonary Disease (COPD). By leveraging clinical data, practices in the Middlebury HSA are able to identify gaps in care and target intervention—such as referring patients to self-management programs, collaborating with care teams on shared care plans, and ensuring that high-risk individuals receive intensive care coordination—which supports improved patient outcomes like A1c control and medication adherence for diabetes and other conditions.

Reducing Deaths by Overdose and Suicide

Two sites in the Middlebury HSA participate in the Blueprint's Hub & Spoke model, which supports individuals with opioid use disorder through medication-assisted treatment and wraparound services. Spokes in both primary care and specialty settings offer ongoing support and behavioral health services. Suicide prevention efforts have been bolstered by embedding mental health professionals within primary care practices and expanding access to counseling services through the Blueprint's Mental Health Integration (MHI) Pilot. These efforts are aligned with statewide goals to reduce preventable deaths and improve behavioral health outcomes.

Improving Access to Primary and Specialty Care

Blueprint-funded staff in the Middlebury HSA serve as community health workers and resource coordinators, helping patients connect with community resources.

> "Flexibility is one of the most valuable aspects of Blueprint's integrated care model. I recently did an intake with a patient who has chemical sensitivities, and instead of a traditional office visit, we did a walking session outdoors. In my everyday practice, I typically need to follow a more structured intake process, and I'm not sure I would've felt comfortable offering that kind of accommodation in another setting. But within this model, I have the freedom to meet patients where they are—literally and emotionally—and create a space that feels safe and supportive from the very beginning."
>
> —-Blueprint MHI-funded Clinician

MORRISVILLE HEALTH SERVICE AREA

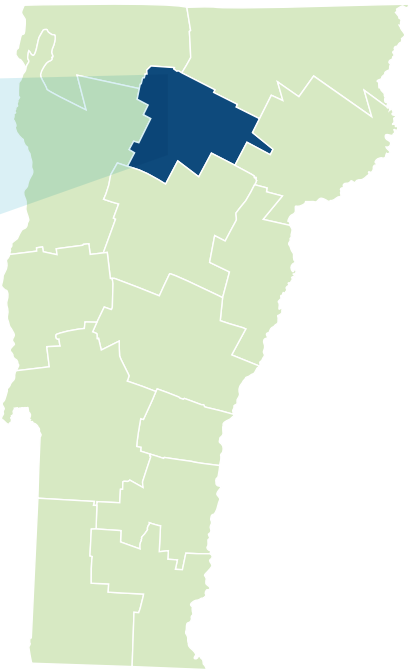
Administrative Entity: Copley Hospital

Program Manager: Corey Perpall

At a Glance

19,745	Health Service Area Total Population
16,597	Blueprint Practices Patient Attribution
3,285	Community Health Team Patient Count*
210	Spoke-Eligible Patient Population‡
15.65	Community Health Team Staff FTE
4	Spoke staff FTE
.5	Pregnancy Intention Initiative Staff FTE

* Community Health Team Patient Count (January–September, 2025—may include duplicates)
‡ Spoke Eligible Patient Population (Average July–September, 2025)



COMMUNITY PARTNER ENGAGEMENT THROUGH TEAM-BASED CARE AND OTHER ACCOMPLISHMENTS

This year the administrative entity transitioned from Lamoille Health Partners (LHP) to Copley Hospital. This summary was primarily provided by LHP. Our partnership with the UVM and Univerity of New Hampshire's master's in social work (MSW) programs has been incredibly successful. This opportunity allows for students to gain experience while increasing capacity for mental health brief intervention and care coordination equally supporting workforce development in our community.

The Substance Use Community Health Worker (CHW) who joined our team, credited to the Mental Health Integration (MHI) Pilot, has completed the Community Health Worker Certification program benefiting resource in the community. This position also includes a lot of outreach in the community including our local emergency shelter, recovery center and warming center. Our Spoke staff has also had a presence at the recovery center. This year Hardwick Area Health Center was also able to implement a food shelf at their office to offer additional resources to their community. Washington County Mental Health Services (WCMHS) Center for Substance Use Services-Morrisville had continued annual vaccine clinics with Health Department.

The Lamoille Health Collaborative continues to meet regularly to discuss better ways to improve connection and resources between service providers. Community Health Team (CHT) staff regularly attend community meetings including the Lamoille Care Management Team, Housing Solutions Team, Continuum of Care, Care Team Meetings and other community collaboration as possible.

To evaluate the health outcomes of CHT services within Lamoille Health Partners, we collaborated with Bi-State Primary Care Association services. The preliminary analysis showed promising gains in improved blood pressure, hemoglobin A1c, emergency room visits, and depression. We look forward to sharing more of these results.

Findhelp implementation has shown great success throughout 2025, with stakeholders' engagement in the closed-loop referral workgroup. We have continued efforts in utilizing the platform for client referrals and information sharing between agencies.

Spoke

There are seven Spoke sites (four primary care, and three specialty clinics) and 26 providers providing Medication for Opioid Use Disorder (MOUD). We are funded for 4.0 full-time equivalent (FTE) staff, fulfilled by nine staff (six RNs, two LADC).

Lamoille Health Partners merged their Stowe and Morrisville locations. This transition has shown benefits in collaboration in patient care and access as providers and Medicine-Assisted Treatment (MAT) Team being in one building. Johnson Health Center (JHC) and the Burlington Health Service Area (HSA) collaborated with central office to establish JHC's Burlington site as a Spoke location.

Treatment Associates was absorbed by WCMHS. After much consideration, we transitioned a pass-through agreement the embedded staff were able to stay and support the position. This allowed WCMHS to maintain their MAT Registered Nurse (RN) full time and support for this role.

Significant efforts to support Hardwick Area Health Center MOUD program. There was a clear need of additional staff that allowed improved program oversight. We were able support a waiver for this by utilizing other resources that Blueprint treatment standards continue to be met.

The Substance Use Disorder (SUD) CHW under the MHI Pilot has been a great bridge between the MAT and CHT Team supporting folks at the Recovery Center, shelter, and community breakfast to establish care.

QUALITY IMPROVEMENT (QI) ACHIEVEMENTS

HSA Data Drive Quality Improvement

- Blueprint Community Health Profile data for the Morrisville HSA was presented to the Lamoille Health Collaborative as part of a larger project prioritization exercise.
- Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey data from the 2024 data collection period has been utilized by all practices in the HSA to inform practice priorities. Participation in CAHPS also meets a Patient Centered Medical Home (PCMH) requirement.

"I need the Community Health Team. They are the most important people in the building."

—Primary Care Provider

Practice Quality Achievements

- Improving Rates of Screening for Depression in Primary Care: A new protocol for depression screening was implemented at the practice. As a result, the rate went up to 60% from 41%.
- Closing the Referral Loop in Primary Care: The practice's referral reconciliation process was improved by improving the associated workflow. As a result, the referral loop was closed 58% of the time, up a full 20 percentage points and exceeding the practice's goal of 50%.

"It made a difference that I had the same (Care Coordinator) even though my doctor changed a few times. I didn't have to start all over."

—Patient

FUTURE GOALS

The focus will be on stabilizing the leadership of the Lamoille Health Collaborative (LHC). The LHC has selected three members to collaborate with Blueprint Program Manager and QI Facilitator to refresh the structure and outputs.

NEWPORT HEALTH SERVICE AREA

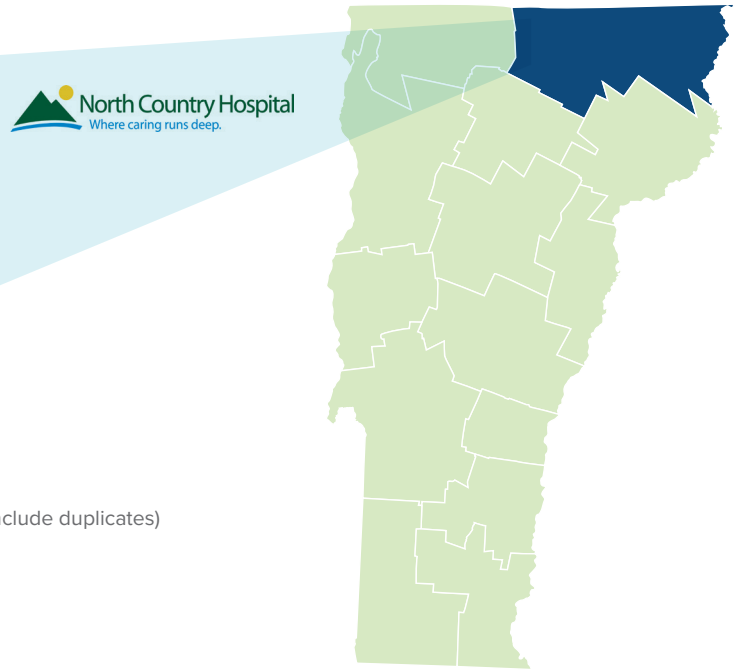
Administrative Entity: North Country Hospital

Program Manager: Meghan Fuller

At a Glance

21,145	Health Service Area Total Population
13,203	Blueprint Practices Patient Attribution
2,281	Community Health Team Patient Count*
162	Spoke-Eligible Patient Population‡
13.69	Community Health Team Staff FTE
3.84	Spoke staff FTE
.5	Pregnancy Intention Initiative Staff FTE

* Community Health Team Patient Count (January–September, 2025—may include duplicates)
‡ Spoke Eligible Patient Population (Average July–September, 2025)



COMMUNITY PARTNER ENGAGEMENT THROUGH TEAM-BASED CARE AND OTHER ACCOMPLISHMENTS

There's been a lot of great work done in the Newport Health Service Area (HSA) over the past year focused on improving Team Based Care (TBC), starting with the work initiated last year with the Camden Coalition that wrapped up in April of this year.

One area of focus has been on improving the discharge process and care coordination of newly diagnosed diabetic patients from the hospital. The unit manager worked closely with our Community Health Team (CHT) Lead to implement an education process that matched what patients would receive from our CHT Care Coordinators and a discharge checklist to ensure patients were discharge with the supplies and information they need to keep them on track until they can follow up with their Primary Care Provider (PCP) and outpatient care coordination. This has been especially beneficial for patients discharging on the weekends and in the evenings.

Another TBC initiative has occurred with our designated agency (DA), Northeast Kingdom Human Services (NKHS). To improve communication and care for our mutual patients, our CHT Lead worked with NKHS on a process where a care manager from NKHS meets with the clinical manager from the primary care practice to discuss the needs and care plans for mutual patients. Our CHT Lead has also worked with University of Vermont Medical Center (UVMC) dialysis team to establish regular team meetings to make sure our dialysis patients are getting everything they need.

As far as ongoing collaborations, the workflows we established with Vermont Chronic Care Initiative (VCCI) continue to work well, providing a more seamless transition between the intensive chronic care coordination VCCI offers and the ongoing care coordination provided by our CHT care coordinators. We continue to work with the Vermont Foodbank and Northeast Kingdom Community Action (NECKA) to help those who need food. A member of our CHT is the site coordinator for Veggie Van Go in Newport, Vermont; and we also have a program called the Barton Drop & Go that provides a monthly food drop for patients who need it at our Barton Primary Care Clinic.

QUALITY IMPROVEMENT (QI) ACHIEVEMENTS

HSA Data-Driven Quality Improvement

We use results from the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey to inform patient experience projects, but for the most part prefer to use our Electronic Medical Record (EMR) generated data for the measures Blueprint sends out as it is more recent. Our practices also do send out patient experience surveys regularly throughout the year so the CAHPS survey data we receive from Blueprint is usually in line with what we're seeing on our ongoing surveys.

Practice Quality Achievements

Improving Depression Screening in Primary Care

As part of our on-going work to maintain our Patient-Centered Medical Home (PCMH) certification, we focused part of our quality work over the last year on improving our depression screening rates. We had done work on this in the past and established a workflow where patients would complete the screening form in the lobby as they waited to be roomed and then rooming staff would transcribe the results into the chart during the intake. We saw our rates had not improved as much as we had expected and upon further analysis discovered that patient forms with negative results were not getting transcribed into the chart. We did some reeducation with staff highlighting the importance of entering the form regardless of score and saw those numbers improve over the course of the year.

"This success story underscores the importance of empowering patients through education, technology, and personalized support. A patient came to me with an A1c of greater than 10%, when it should be less than 7%. His knowledge of diabetes was limited, but he was determined to take control of his health and avoid the diabetic complications he had seen a family member suffer. We implemented a plan that included insulin therapy, continuous glucose monitoring (CGM) technology, and biweekly coaching sessions focused on physical activity, meal planning, medication adherence and use of the CGM. In less than six months, the patient had an A1c of 5.9% and had transitioned off insulin. This case highlights the effectiveness and the importance of the Vermont Blueprint for Health health care initiatives. This patient's improved health outcomes will help control costs through patient-centered education tailored to individual needs. Lifestyle coaching and behavioral support also were a huge factor with his success.

—Chronic Care Coordinator

FUTURE GOALS

A major focus for the coming year will continue to focus on our diabetic patients. Our CHT Lead and chronic care coordinators have put in a lot of work coordinating with the hospital and providing training to inpatient nursing staff regarding education and care of newly diagnosed diabetic patients. We will continue to evaluate the effectiveness of the process put into place this past summer and continue to refine it as needed to ensure our inpatient discharges do not turn up in the Emergency Department a day or two later with diabetic problems.

"I received a referral for a client recently diagnosed with cancer. The referral was initially for assistance with transportation and appointment management, but further assessment revealed significant social determinants of health needs. The patient had a history of missed appointments and difficulty in performing daily living tasks. She faced eviction and risked losing her housing voucher. Her Medicaid coverage had lapsed, delaying transportation arrangements. Her living conditions were unsafe, and she slept on the kitchen floor because the bedroom was filled with belongings. After weeks of collaboration with Medicaid navigators and assisting the client in locating the required documents, insurance coverage was restored. Daily calls encouraged the process of decluttering to prepare for post-surgery recovery. After surgery, the patient required 10 weeks of daily radiation treatments. Morning reminder calls ensured readiness for transportation. Today, the patient sleeps in a clean bedroom and has an organized apartment. She is receiving Meals on Wheels and connected to the Council on Aging. She is independently arranging transportation for her appointments.

—Chronic Care Coordinator

"Over the past year, I have supported numerous individuals and families in navigating essential resources that improve their quality of life. Whether assisting with housing, food security, or home weatherization services, I have had the opportunity to make a meaningful difference in the lives of many. One of the most impactful experiences was when I received a referral to assist a mother and daughter in securing stable housing. During our initial meeting, they shared the emotional and psychological toll their current situation was having on them, and it became clear that their home environment had deteriorated to the point of being mentally unsafe. We began exploring housing options, submitted multiple applications and were placed on waiting lists, with anywhere from 10–200 applicants ahead of them. During this time, I maintained regular contact, providing support through local resources and connecting them with a nearby mental health program. Weekly check-ins helped ensure their safety and well-being. They received notice that an apartment had become available. I provided continued guidance and reassurance to help ease the process of relocating and adjusting to their new environment. As I write this, they have been living in their new home for over a month, and their sense of stability continues to grow each day."

—MHI Community Health Worker

RANDOLPH HEALTH SERVICE AREA

Administrative Entity: Gifford Health Care

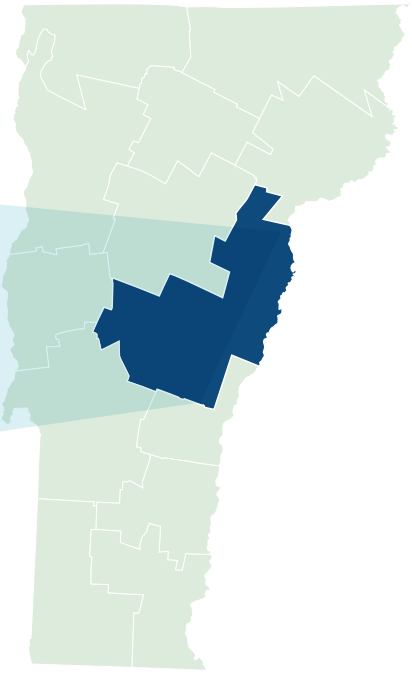
Program Manager: Anthony Knox

At a Glance

- Health Service Area Total Population
- Blueprint Practices Patient Attribution
- Community Health Team Patient Count*
- Spoke-Eligible Patient Population‡
- Community Health Team Staff FTE
- Spoke staff FTE
- Pregnancy Intention Initiative Staff FTE

* Community Health Team Patient Count (January–September, 2025—may include duplicates)
‡ Spoke Eligible Patient Population (Average July–September, 2025)

Gifford Health Care



COMMUNITY ENGAGEMENT THROUGH TEAM-BASED CARE AND OTHER ACCOMPLISHMENTS

This past year has been one of growth and resilience in the Randolph Health Service Area (HSA). Despite ongoing challenges, our team has expanded services, strengthened community partnerships, and made progress toward team-based care. This year the focus has been on three areas: reconfiguration and expansion of the Community Health Team (CHT), re-establishment of the Community Collaborative Meeting, and refocusing on key community partnerships.

With a shift in strategy for the Mental Health Integration (MHI) Pilot grant funding, Gifford was able to hire an additional 2.5 FTE Community Health Workers (CHW), who are focused on supporting connection with mental health organizations as well as community supports for identified social needs that impact people's ability to access care and impact their overall wellbeing. With these new positions and some retirements, we have seen the largest influx of fresh staff since the inception of the team at Gifford. It has given us the ability to reevaluate how we do work, direct attention to workflows, and support training on the many organizations we collaborate with in our community.

At the end of 2024, there was a successful relaunch of our Community Collaborative, Greater Randolph Area Support Services (GRASS). We are happy to report that this meeting has maintained strong engagement across many community partners. In the last few months we have been working to better define the purpose and role of this meeting, and the goals we have as a community. This has led to a deep dive into Gifford's 2024 Community Health Needs Assessment to help guide our work.

The third area of focus has been deepening the connection between clinical and community partners to further advance team-based care. At the end of May, the CHT engaged with Gifford Hospital on a "Rounds Pilot," where a member of the Blueprint Team started to attend interdisciplinary rounds at the hospital to help support more timely referrals to the CHT and other supports within Primary Care. We have seen remarkable success with this program, including being able to connect with patients more timely upon discharge from acute care.

"She made me feel like I was in control. [They are] an unseen hero—doing work in the background that nobody sees, work that saves lives."

—MOUD patient

QUALITY IMPROVEMENT (QI) ACHIEVEMENTS

This year there have been strong quality improvement efforts in two areas: high utilization of the Emergency Department (ED) and improving access to primary care.

There has been focused effort with CHT and Population Health in the last year on better defining the cohort for ED High Utilization and development of referral pathways to primary care, CHT, and other community partnerships to support patients with the root drivers of utilization.

In addition, in response to the 2024 Community Health Needs Assessment and Consumer Assessment of Health Care Providers and Systems (CAHPS) data, there has been significant work to address access in Primary Care. Gifford now has a dedicated work-group addressing this multi-faceted issue. Their work includes ensuring accurate panels and right-sizing panels, utilizing tools within their Electronic Health Record (EHR) to support scheduling access, and creating Provider Dashboards with information on panel size and productivity, as well as monthly report-out to clinic leadership on the status of different initiatives around increasing access to care. Key access metrics include "Third Next Available Appointment" and wait list volume. Overall, the data has demonstrated that there have been great strides made with improving access, and it is clear where additional providers need to be hired to support clinic volumes.

FUTURE GOALS

Looking toward the future brings with it some uncertainty, given our current environment of care. With monumental change at a state and federal level, the work and commitment of our community teams continue to remain strong. We are adding two new practices to our health service area, Little Rivers Health Care and Upper Valley Pediatics, and are looking forward to countywide engagement and support. The primary goals for the next year are to continue to build and develop our community teams, build capacity for the work, and to remain engaged in local conversations about health care transformation work. With a new team and reengagement of our community partners through GRASS we hope to further stabilize the support network in our health service area, improve our communications and systems for referrals, and help to integrate the two new practices in our HSA into this work.

"[She] has looked out for me through the last decade, ensuring I had the support I desperately needed at the start of my journey. I wouldn't be a successful, productive member of society if it weren't for [her] believing in me when I didn't believe in myself. Caring for me more than I cared for myself and guiding me through the darkest of times. She has watched my kids grow along side of me in recovery. I have followed [her] through three or four different providers, yet she has remained constant. A friendly face, a caring soul"

—Patient about an MOUD RN

"CHT is an asset to the Berlin Clinic. They are extremely helpful with navigating patient needs and advocating for them including transportation, housing, insurance, and medication access, and talking with families about future plans for care in the home or in a care facility. They are a great support to staff helping us talk through our decision making for the best possible outcome for our patients."

—Office Manager

"Our Community Health Team has been an invaluable addition to our pediatric clinic, extending the support we are able to provide to patients and their families. CHT involvement has strengthened our ability to address the needs of our patients beyond the exam room by connecting families with resources such as food assistance, stable housing options, counseling services, school meetings, and community resource coordination. This partnership between our clinic staff and CHT has allowed the providers to focus more on the medical and development needs of our patients, while the CHT can support the broader social factors the ultimately influence overall health. By addressing the big-picture needs that impact our patients and families, the CHT has helped us promote better comprehensive, coordinated and effective care."

—Provider

RUTLAND HEALTH SERVICE AREA

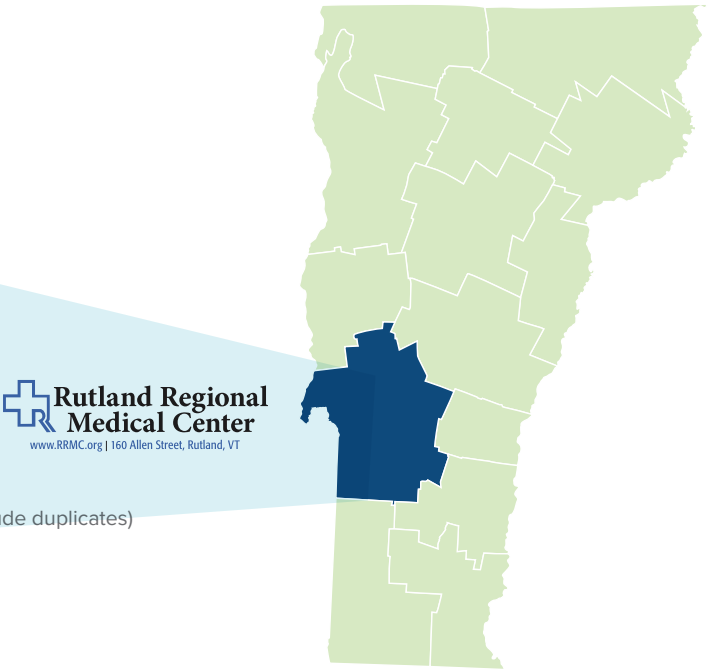
Administrative Entity: Rutland Regional Medical Center

Program Manager: Merideth Drude

At a Glance

- Health Service Area Total Population
- Blueprint Practices Patient Attribution
- Community Health Team Patient Count*
- Spoke-Eligible Patient Population‡
- Community Health Team Staff FTE
- Spoke staff FTE
- Pregnancy Intention Initiative Staff FTE

* Community Health Team Patient Count (January–September, 2025—may include duplicates)
‡ Spoke Eligible Patient Population (Average July–September, 2025)



COMMUNITY ENGAGEMENT THROUGH TEAM-BASED CARE AND OTHER ACCOMPLISHMENTS

The Rutland Community Health Team (CHT) demonstrates the impact well-coordinated care and community-based interventions can have in reducing the amount of non-emergent care in our Emergency Departments (ED). Patients who have utilized ED services more than four times in the last six months are eligible for CHT outreach to explore potential needs and barriers to care outside of the ED. This outreach includes completing Social Drivers of Health (SDOH) screening as well as identifying care-team members who may support increased engagement with primary care providers and other beneficial community resources.

Data demonstrates that from the initiation of CHT services, there is an average 59% reduction of ED utilization when comparing pre- and post-CHT engagement. This is accomplished through team-based care coordination between CHT and Patient-Centered Medical Homes (PCMH) along with community-based agencies using a patient-centered model that controls health care spending along with resource allocation improvements, while improving quality of life.

The Rutland Pediatric CHT provides equally essential support for our pediatric community. Each quarter, more than 450 unique pediatric patients and families are reached by our CHT Pediatric team. This care-coordination effort employs both nursing and social work outreach to address medical and psycho-social complexities.

Caregivers are offered comprehensive care-coordination support to ensure seamless care between pediatric providers and specialists, all while supporting caregivers to understand care needs and services and the means to access them. The Pediatric CHT supports children across the spectrum of where they learn, live and play, which requires strong community partnerships and team-care coordination.

The Pregnancy Intention Initiative (PII) is another highlight of Blueprint efforts in the Rutland Health Service Area (RHSA). Rutland Women's Healthcare has been an active participant in PII since its inception. This past year there were a total of 3,329 unique individuals screened; and 51% of those screens were positive for at least one SDOH need. The three most prevalent SDOH needs are related to marijuana use, tobacco use, and pregnancy intention.

While the screening is a well-defined opportunity to access the support from the PII Behavioral Health Specialist, patients also have the ability and access to self-refer for this readily identified and available source of support. This past year 227 individuals were supported outside of a positive screen. Our goal is to eliminate barriers for our community to get access to care and services they need and this effort demonstrates the demand for such support.

DATA-DRIVEN QUALITY IMPROVEMENT (QI)

The Rutland HSA (RHSA) has a new QI Facilitator who began in December 2024. The focus during 2025 has been building a solid relationship between our PCMH and QI Facilitator. The QI Facilitator utilized Blueprint's public-facing Community Health Profiles and individual Practice Profiles supplied by the Blueprint Central Office. The QI Facilitator engaged each PCMH by providing notes on their Practice's performance compared to State of Vermont data over the same measures and held focused discussions with them on proactive measures such as well-visits, developmental, and cancer screenings. Community Profiles show the Rutland HSA underperforming in these domains compared to the State of Vermont. While there are still many layers to Practice systems and workflows that will need to be explored, an immediate outcome was for one organization opening their provider panels for new patients after a three-year hiatus.

During the organization's pause of accepting new patients, Rutland Regional Medical Center (RRMC) saw increased rates of ED utilization, which may have been informed by patients seeking out higher-cost care when local primary care was impinged. RRMC is hoping a corresponding reduction in ED visits will result from patients having greater access to primary care.

The RHSA QI is focused on consistency of data to best understand how the HSA can work collaboratively to improve patient needs. With this in mind, QI is engaging in a transformation process with our local community collaborative. One goal of this process is to align improvement measures to show where mutual goals exist. This will allow community collaborative members to better identify goals and actions that can be implemented across the RHSA in support of patient care.

"We show up every day and do better than the day before. We navigate the challenges families are experiencing, from homelessness, substance use, food insecurity to the most medically complex diagnoses. Our goal is to maintain the safety, health, and well-being of all children and families we serve."

—A Pediatric RN CHT Case Manager

FUTURE GOALS

An opportunity the RHSA has taken is within hospice and palliative care. The RHSA has higher rates of conditions such as Chronic Obstructive Pulmonary Disease (COPD), Diabetes, and higher readmission rates for COPD and congestive heart failure. The RRMC census has shown a higher utilization of inpatient hospice care versus home care for end of life. The CHT received approval from the Blueprint Central Office to provide a year pilot for a Palliative and Hospice Registered Nurse (RN) Care Coordinator to support sooner access to care. We hope to see lower rates of patient end of life care occurring in the hospital setting whenever clinically appropriate with a goal to reduce cost while increasing quality of life outcomes for both patients and families.

"Blueprint funding has been instrumental in allowing Bradford Psychiatric Associates to offer expanded services, including care coordination and direct mental heath support. We believe these services have significantly improved patient care and continued to decreasing other rising healthcare costs within the community."

—Provider

SPRINGFIELD HEALTH SERVICE AREA

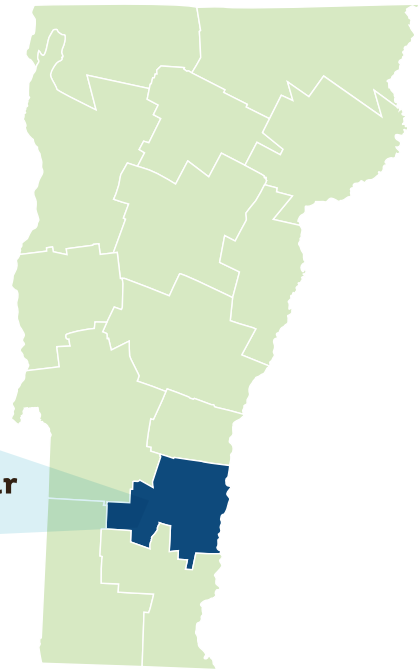
Administrative Entity: North Star Health

Program Manager: Tom Dougherty

At a Glance

- Health Service Area Total Population
- Blueprint Practices Patient Attribution
- Community Health Team Patient Count*
- Spoke-Eligible Patient Population‡
- Community Health Team Staff FTE
- Spoke staff FTE
- Pregnancy Intention Initiative Staff FTE

* Community Health Team Patient Count (January–September, 2025—may include duplicates)
‡ Spoke Eligible Patient Population (Average July–September, 2025)



COMMUNITY PARTNER ENGAGEMENT THROUGH TEAM-BASED CARE AND OTHER ACCOMPLISHMENTS

In 2025 a diverse group of community partners from across the Springfield Health Service Area (HSA) collaborated in a new and innovative way to address the issues of mental health, housing, and substance abuse that had reached crisis levels in the town of Springfield. Following the Safety Summits convened by Governor Scott and the Public Safety Enhancement Team (PSET), organizations including the police department, the designated mental health agency (DA) HCRS (Health Care & Rehabilitation Services), the local Patient-Centered Medical Home (PCMH) North Star Health, Springfield Supportive Housing, and the local Area Agency on Aging (AAA) Senior Solutions, along with representatives from the town, the Department of Parole, the Agency of Human Services and other service providers launched Project ACTION (Assembling Community to Improve our Neighborhoods). Adapting team-based care best practices, they convened a weekly "community table" open meeting where residents and organization reps raise issues of concern, suggest solutions, and identify resources. This is followed by a "situation table" where service organizations address situations of an acute, elevated risk and develop a team-based response to engage and assist individuals. The result has been targeted, coordinated interventions that have led to individuals with complex problems receiving critical services including housing assistance, substance use treatment, mental health services, and healthcare, all while improving neighborhood safety and the community's ability to develop solutions and target resources for sustainable improvements in the town's quality of life for everyone, particularly those who are most vulnerable.

"Our Community Health Workers (CHW) build trusted relationships with individuals and families by meeting them where they are—literally and figuratively—to address barriers such as housing, food security, financial assistance, transportation, and mental health. They offer a personalized and compassionate approach, empowering our patients to navigate complex systems, access essential resources, and make sustainable progress toward their goals. By extending the reach of health care beyond the clinic and into the hearts of our communities, our work ensures that each person feels seen, supported, and cared for when they need it most."

—Primary Care Team member

PRACTICE QUALITY IMPROVEMENT (QI) ACHIEVEMENTS

Combatting high blood pressure (hypertension) and specifically improving the rate of hypertension in control for individuals age 18-85 with a hypertension diagnosis, has been a priority for each of the PCMH practices in our service area, given the prevalence of hypertension in our community (nearly half of all adults have it) and the fact it is a leading or contributing cause of over 680,000 deaths in the USA each year. To improve a baseline level of hypertension in control of between 62 and 72 percent across four practices, North Star Health trained staff on best practices and on our documentation workflows, and enhanced patient education during primary care visits over a period of five months, resulting in improvements at three of the four practices to rates between 65 and 77 percent!

> "I am grateful for the flexibility of being able to meet patients wherever they are in the community. We provide care for a large population of unhoused people, and I've been able to go to campsites to bring medical supplies and toiletry items, which has a more positive impact on health outcomes."
>
> —Primary Care CHW

FUTURE GOALS

Our experiences in 2025 in enhancing our cross-organization collaboration has provided our HSA with ample evidence of what works and what remains to be done. Following the completion of our latest Community Health Needs Assessment (CHNA) in August, our PCMH practices and community partners are developing action plans that will build on the successes of Project ACTION and community outreach programs, will support the launch of our DA as a Certified Community Behavioral Health Center, will include regional care transformation plans for our hospital, and will see our health centers continue their initiatives to improve the access to and quality of primary care.

> "A community health team is more than a group of professionals, it's a lifeline. When we work together, we don't just treat a person's physical health, we build trust, dignity, and the kind of support that helps a community thrive."
>
> —Primary Care CHW

ST. ALBANS HEALTH SERVICE AREA

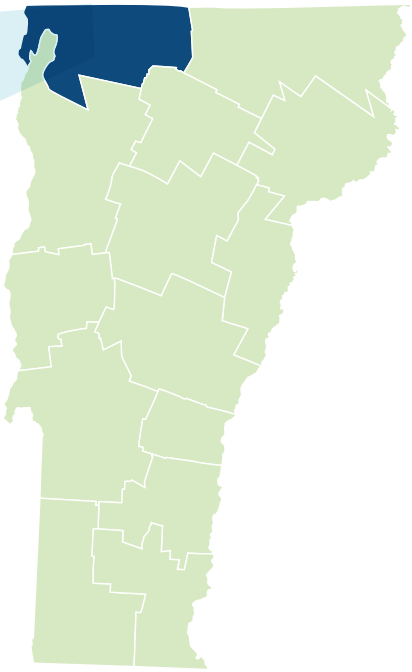
Administrative Entity: Northwestern Vermont Medical Center

Program Manager: Jessica Frost

At a Glance

- Health Service Area Total Population
- Blueprint Practices Patient Attribution
- Community Health Team Patient Count*
- Spoke-Eligible Patient Population‡
- Community Health Team Staff FTE
- Spoke staff FTE
- Pregnancy Intention Initiative Staff FTE

* Community Health Team Patient Count (January–September, 2025—may include duplicates)
‡ Spoke Eligible Patient Population (Average July–September, 2025)



COMMUNITY PARTNER ENGAGEMENT THROUGH TEAM-BASED CARE AND OTHER ACCOMPLISHMENTS

Team-Based Care Initiative

The St. Albans Health Service Area (HSA) partnered with the Community Health Team (CHT) and local organizations to explore Team-Based Care (TBC). Our Quality Improvement (QI) Facilitator participated in Camden Coalition meetings and worked with the change team to identify patients who would benefit most. Two priority cohorts were selected:

- Pediatric: Children with Department for Children and Families (DCF) involvement, truancy history, and substance use.
- Adult: Individuals with frequent Emergency Department (ED) visits related to substance use disorder and unmet Social Determinants of Health (SDOH) needs.

Partners collaborated to design a standardized care plan template to meet multiple organizations' needs. A one-page overview was created to explain TBC and its benefits to partners and potential patients. Engagement included representatives from primary care, Federally Qualified Health Center (FQHC), Medication for Opioid Use Disorder (MOUD) clinics, home health agencies, state health officials, Support and Services at Home (SASH), our designated agency, and Northwestern Medical Center's Emergency Department (ED) leadership. Presentations from Vermont Department of Health's (VDH) Family and Child Health Coordinator and Agency of Human Services's (AHS) Chronic Care Initiative provided insight into the Children and Recovering Mothers (CHARM) model and other TBC strategies.

Wound Care Access Initiative

Community partners identified a significant gap in outpatient wound care services, contributing to increased ED utilization and inpatient admissions. A survey revealed key barriers: limited skilled nursing capacity, lack of education for patients and staff, and challenges with supplies and reimbursement. In response, the Blueprint team allocated CHT funds to hire a certified wound and ostomy nurse (WOCNCB) to provide care within primary care offices. This initiative improved access to wound care within patients' medical homes and reduced avoidable ED visits.

Key Outcomes:

- 80 patients treated in primary care since launch.
- Three educational sessions delivered on xylazine wounds, foot ulcers, and pressure sores.
- Established an email consultation system for timely provider support.

An in-depth Wound Care Associate course will soon be offered to CHT members, further expanding local expertise. This program has strengthened care coordination, enhanced provider education, and improved wound care access across the HSA.

QUALITY IMPROVEMENT (QI) ACHIEVEMENTS

HSA Data-Driven Quality Improvement

Blueprint Community Health Profiles and Practice Profiles guided efforts to improve hypertension in control and access to care. Five-year trends revealed a strong correlation between high positive Social Drivers of Health (SDOH) screenings and lower hypertension in control rates. Patients facing food insecurity, housing instability, or transportation challenges often struggle with medication adherence and consistent care.

Local practices leverage intuitive Electronic Health Record (EHR) systems for comprehensive data pulls, enabling meaningful quality initiatives. Increasing SDOH screening has been a priority, allowing practices to connect patients with resources such as food programs, transportation vouchers, and housing support. Addressing these needs improves medication adherence, follow-up rates, and blood pressure control. These efforts have contributed to better hypertension outcomes and improved Consumer Assessment of Healthcare Providers and Systems (CAHPS) access-to-care scores.

"There are many moments as a member of the CHT which have been meaningful with my patients.

- I had the time to help a patient with Medicare due to recent changes with the Advantage plans. The patient said "I would never have been able to do this without your help. Thank you so much".
- I am able to provide education to patients to help them lose weight. People who have success are very appreciative with the tips and education provided.
- When I follow up with patients who have visited the Emergency Department, they say: "Thank you very much for checking in on me". They know their PCP is aware of the hospital visit they had."

—RN Care Manager

Practice Quality Achievements

The Wound Care Pilot Program described above is a direct result of collaborative QI work.

School Truancy Initiative:

An emerging QI project is addressing school truancy through pediatric primary care screening and care coordination. Recognizing the strong link between school attendance and overall health, practices began incorporating truancy screening into routine wellness visits to identify underlying social, behavioral, or health factors contributing to absenteeism.

Collaboration with a local school district has created a shared support network for families. When barriers such as behavioral health needs, transportation challenges, or family stressors are identified, providers initiate coordinated interventions to connect families with appropriate resources and support.

During annual wellness visits, patients aged 5–18 years complete a brief questionnaire that asks: In the past 30 days, how often have you missed school?

- 0–1 days
- 2+ days

If 2+ days, why?

- Illness
- Chronic pain (e.g., headaches, stomach pain)
- Anxiety/depression
- Suspension
- Transportation issues
- Safety concerns
- Other

Providers review responses during the visit. If a patient screens positive, they offer a referral to the appropriate CHT member, a counselor or registered nurse, who follows up to address the underlying issues. This may include problem-solving, providing resources, or connecting families to outside providers for additional support.

Implementation and Early Results:

Screening began on May 1, 2025, with a baseline of zero patients screened.

Between May 1 and July 1, 2025:

- Total patients: 3,264
- Screened: 264 (8.1%)
- Positive for attendance concerns: 81 (30.7%)
  - Illness: 37 (45.7%)
  - Anxiety/depression: 11 (13.6%)
  - Suspension: 2 (2.5%)
  - Safety concerns: 1 (1.2%)

As of November 3, 2025, cumulative data show:

- Total patients: 3,535
- Screened: 818 (23.1%)
- Positive for attendance concerns: 173 (21.1%)
  - Illness: 68 (39.3%)
  - Anxiety/depression: 25 (14.5%)
  - Suspension: 2 (1.2%)
  - Safety concerns: 3 (1.7%)

Integrated Approach:

Screening data are compared with CMS-10 SDOH results to identify patients with overlapping social needs. Monarch Maples now develops care plans for any patient who screens positive for both school attendance and SDOH concerns and is willing to engage in services, ensuring full wraparound support.

This initiative promotes early intervention, strengthens family-centered care, and improves both educational and health outcomes for children and adolescents in our community.

"As RN care managers, we screen patients who have elevated AIC for diabetes and offer CCM. I had a patient who I screened, at beginning of year, whose AIC was 11.8. At first, she wanted nothing to do with RN care management, but with frequent check-ins during office visits, time to build a relationship with her, education, and getting her started on continuous glucose monitoring, eight months later her A1C is at 6.4. She was brushing off her diabetes, and now she is so happy that it is under better control, she feels better and has more energy."

—RN Care Manager

FUTURE GOALS

Our HSA aims to use high-quality, integrated data to inform equitable care strategies—connecting clinical and social care systems, expanding access to needed services, and improving chronic disease and behavioral health outcomes. We will continue building on current QI efforts by:

- Strengthening chronic disease management and expanding access to care.
- Deepening use of Blueprint data to identify gaps in hypertension and diabetes control.
- Expanding SDOH screening and integrating data into care planning.
- Building on the Wound Care Pilot Program with teleconsultation capacity.
- Improving data quality and integration between EHRs, Blueprint systems, and Vermont Health Information Exchange (VHIE) to support population health insights.

"For the past ten years, on and off, I have had the privilege of providing short-term, episodic mental health therapy—free of cost—to children, youth, and families in rural Vermont. Throughout this time, I've seen how transformative accessible, timely support can be, especially in small communities where resources are limited, stigma is high, and families often feel they have nowhere to turn.

A significant part of this work has involved supporting suicidal youth and those experiencing acute emotional distress. Being embedded directly in the pediatric office means we can meet young people at the exact moment they disclose their struggles—often unexpectedly, during routine medical visits when they feel safest. This immediacy reduces stigma, eliminates barriers to care, and provides families with support at a time when early intervention can make all the difference.

In these moments, our role becomes essential: creating safety plans, helping families understand and respond to risk, and connecting them with resources they may not have known existed. I've seen first-hand how even a single, well-timed session can shift the trajectory of a crisis—offering grounding, hope, and a path forward.

Another deeply meaningful part of this work has been providing affirming mental-health support to LGBTQAI+ youth. In rural areas, many young people lack access to safe, identity-affirming spaces or providers who understand the unique challenges they face. For some, the pediatric office is the first place where they feel comfortable expressing questions about identity, sharing experiences of rejection, or describing the stress of hiding who they are. Offering them a nonjudgmental, supportive space—and helping their families navigate these conversations—can be life-changing. In many cases, this support fills a gap that would otherwise remain unaddressed.

Short-term therapy allows us to focus on immediate needs: building coping skills, strengthening communication, reducing distress, and supporting youth and families until longer-term services can be accessed—or in some cases eliminating the need for higher-level care altogether. These small but powerful shifts are rarely captured in data, yet they are the foundation of long-term resilience.

Over the years, I've witnessed countless quiet transformations: a teen who begins to trust that their feelings matter; a family who learns to move through crisis with compassion instead of fear; a young person who discovers words for emotions or identities they've struggled to name. These moments strengthen not only individual lives but the overall health of our rural community.

The MHI/Blueprint program makes this work possible. Its funding embeds mental-health care directly within pediatric settings—places families already trust—removing stigma, cost, transportation barriers, and long wait times. It allows us to respond early, support youth in crisis, provide identity-affirming care, and offer a consistent therapeutic presence where it matters most.

I am deeply grateful for the opportunity to do this work and for the profound impact it has had on children, youth, families, and our community. Continued support for MHI/Blueprint funding is essential—not only to sustain these services, but to ensure that every young person in rural Vermont, including those most vulnerable or marginalized, has access to compassionate, timely, and life-affirming mental health care."

—MHI LICSW, Pediatrics

ST. JOHNSBURY HEALTH SERVICE AREA

Administrative Entity: Northeastern Vermont Regional Hospital

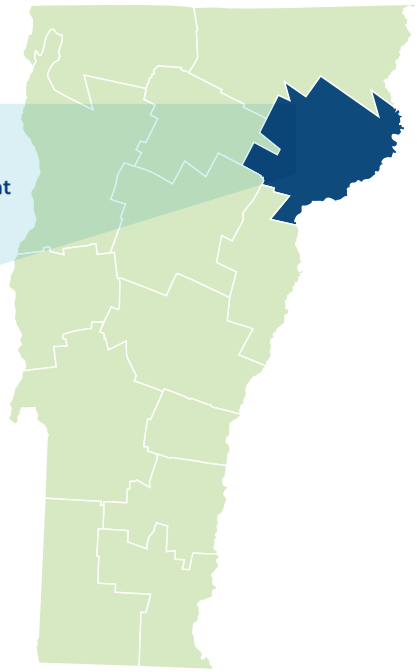
Program Manager: Diana Gibbs

At a Glance

[redacted]	Health Service Area Total Population
[redacted]	Blueprint Practices Patient Attribution
[redacted]	Community Health Team Patient Count*
[redacted]	Spoke-Eligible Patient Population‡
[redacted]	Community Health Team Staff FTE
[redacted]	Spoke staff FTE
[redacted]	Pregnancy Intention Initiative Staff FTE

* Community Health Team Patient Count (January–September, 2025—may include duplicates)
‡ Spoke Eligible Patient Population (Average July–September, 2025)

Choosing Health
Northeastern Vermont Regional Hospital



COMMUNITY PARTNER ENGAGEMENT THROUGH TEAM-BASED CARE AND OTHER ACCOMPLISHMENTS

Throughout 2025, the St. Johnsbury Health Service Area (HSA) has made significant strides in enhancing community collaboration and improving patient outcomes, largely driven by our commitment to Team Based Care (TBC). These efforts have fostered stronger relationships across diverse health care and social service sectors, with a continued focus on transitions of care, care coordination, and suicide prevention pathways. We have executed an Organized Health Care Arrangement (OHCA) with three other critical partners, Northern Counties Health Care (NCHC), Northeast Kingdom Council on Aging (NEK COA), and Northeast Kingdom Human Services (NKHS), to support greater care coordination communication for timely discharge planning and supporting transitions of care. The impact of this work is reflected in numerous successful initiatives that have enriched patient care and fostered a more coordinated experience for our community members.

This year, we expanded our TBC initiatives with strong leadership from the Vermont Team-Based Care (VTBC) workgroup. A new TBC manual, tailored to our HSA, now guides standardized, best-practice workflows. Updated training incorporating Agency of Human Services (AHS)-supported VTBC videos has strengthened shared understanding among care teams. We also formalized collaboration through a TBC commitment agreement, uniting community partners in a pledge to actively participate and enhance communication, trust, and coordinated care across the region.

NVRH is a key leader supporting the facilitation of an exciting model, called the Situation Table. This risk-based, rapid triage model has forged a connection with emergency service providers, including law enforcement, EMS, and fire departments, into the TBC framework. Sector representation is broad, including local schools, corrections, and several other local health and human services providers, creating a rapid approach to addressing urgent needs within our community.

> "It is so helpful to have someone on site I can pull in for a warm handoff or ask to reach out to a patient. I know the Peer Support Worker [Mental Health Integration CHT] will follow through and provide respectful support, whether emotional, logistical, or otherwise. She and this program are an integral part of patient-centered care!""
>
> —APRN

Over the past year, we have strengthened our shared vision and partnerships, with Community Health Teams (CHTs) and Community Health Workers (CHWs) playing a key role in connecting individuals to the right resources. Collaboration with partners like SASH, Caledonia Home Health and Hospice, and Age Well has deepened engagement in Integrated Care Team and Core Team meetings, improving service coordination and patient experience. Enhanced warm handoffs and team-based approaches have led to smoother transitions and better outcomes, with one Core Team member noting, "This group makes me a better Care Coordinator."

NVRH continues to advance suicide prevention through improved coordination and workflow development. Building on prior Vermont Program for Health Care Quality (VPQHC) mini-grant successes in primary care, recent efforts have focused on enhancing Emergency Department processes with VPQHC and NKHS. Direct EMR documentation by NKHS—the local designated agency—and strengthened orientation processes have significantly improved timely data entry and care coordination. The integration of the Stanley Brown Safety Plan into the EMR now allows the full care team to access and act on safety plans more effectively. Current priorities include refining warm-handoff processes to reduce readmissions and to better connect patients with the services and resources that will best meet their needs.

Regarding the Accountable Community for Health (ACH), NEK Prosper!, NVRH had taken back over as the Backbone Facilitator as of late September 2024. Since that time, we have seen a significant shift and progress in identifying a meaningful focus for the broader network and collaborative action networks (CANs) and are integrating results-based accountability approaches to ensure we measure the impact of the work. Given our recent success, we've been asked to meet with the ACH in Washington County, THRIVE, to discuss peer learning and other collaborative opportunities, and to discuss merging or supporting the ACH in the Newport HSA.

QUALITY IMPROVEMENT (QI) ACHIEVEMENTS

On the quality improvement front, we have utilized Blueprint data sets to drive targeted initiatives. For example, CAHPS patient experience surveys have helped identify areas for improvement in patient care. By analyzing the feedback, practices were able to make adjustments that improved patient satisfaction. Similarly, practice profiles highlighted data variations, leading to better data collection methods and informed decisions about where to focus improvement efforts.

One key quality improvement initiative involved Controlling High Blood Pressure at Kingdom Internal Medicine. With a baseline performance rate of 69%, the practice implemented workflow changes to improve the accuracy of blood pressure readings, resulting in an increased performance rate to 73%. While this improvement was modest, it highlighted the value of accurate data and set the stage for further hypertension management efforts.

Similarly, Concord Health Center focused on improving BMI Screening and follow-up plans. By updating chart preparation workflows and improving staff training, the practice improved its performance from 22% to 36% over the course of the year. Although the goal was not fully achieved, the initiative provided valuable lessons that will guide future improvements.

"Having the CHW [Community Health Worker] is a blessing for our patients. I recently had a patient who was coming solely to discuss social determinants of health—being homeless and needing access to temporary shelter for the coming winter. I reached out to the CHW in advance of the appointment, and she was able to provide me the needed forms to complete and met with patient and me to confirm the needs. She reached out to the social service agency to network on the patient's behalf. Having this available enabled me to care for this patient and remain on time in my hectic schedule to be able to continue caring for the other patients in our office. Having the CHW in our office helps with defining the true meaning of Team-Based Care. We also have a Care Coordinator in the office. Her invaluable outreach to the patients helps with safe discharges from the hospital. She also does chronic care management, which allows us to care for more patients as we don't have to bring the care managed patients into the office as often since they are having regular touchpoints with the Care Coordinator who brings issues to our attention."

—Medical Provider

FUTURE GOALS

Looking ahead, our HSA remains committed to supporting ongoing efforts in TBC and chronic disease management, suicide prevention, and ensuring access to the continuum of substance use services. Key initiatives include expanding the Recovery Coach program in the emergency department, supporting hypertension management in line with recommendations from statewide committees, and increasing referrals and utilization of My Healthy Vermont (MHVT) self-management workshops. Through additional funding support, we will continue strengthening our partnerships with local schools to reduce absenteeism through stronger student and family engagement via an embedded CHW who works closely with our pediatric practice.

As we move forward, the goal is to continue this momentum, strengthening community partnerships and ensuring that our collaborative, innovative, and data-driven approach leads to sustainable improvements in the health and well-being of our community. We will leverage our strengths that include cross-sector collaboration (healthcare, public safety, justice, social services); effective integration of behavioral health and CHW roles into TBC models; proactive system-level coordination around care transitions and mental health; and revitalized community collaboration under NEK Prosper! with data-driven accountability.

"I believe that with overcoming my own life experiences of struggling with my own addictions, insecurities, moments of helpless despair/depression/suicide ideation—that I am able to provide services to a wide variety of individuals from all walks of life, including age, sex, race, sexual orientation or identity. I want people to know that hope is walking with them and that there is light in their darkest times. The Blueprint Mental Health Integration (MHI) Peer Support Worker role allows me to offer this to all primary care patients who wouldn't otherwise reach out for help or go to a mental health counselor."

— MHI CHW/Peer Support Worker

"A patient arrived for a scheduled office visit ready to engage with substance use treatment. As that needs to be initiated by the patient, the CHW [MHI CHT] sat with her, explained what needed to happen, and stayed with the patient while she made the phone call to the treatment facility. The CHW spent over 30 minutes with the patient, time that neither the provider nor rooming staff would have been able to spend, and the patient received support and encouragement while making that difficult call."

—APRN

WINDSOR HEALTH SERVICE AREA

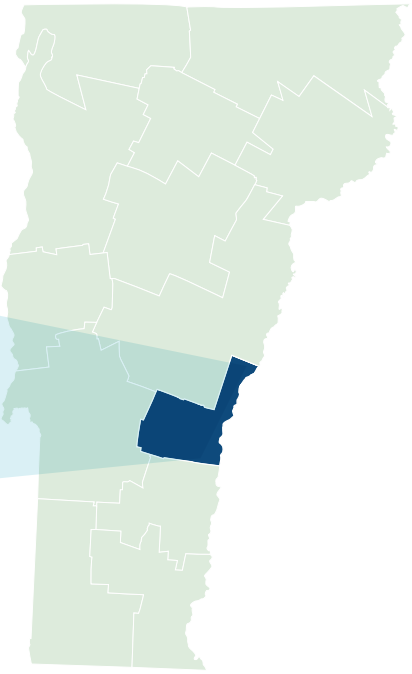
Administrative Entity: Dartmouth Health/Mt. Ascutney Hospital and Health Center

Program Manager: Amanda Jordan Smith

At a Glance

- Health Service Area Total Population
- Blueprint Practices Patient Attribution
- Community Health Team Patient Count*
- Spoke-Eligible Patient Population‡
- Community Health Team Staff FTE
- Spoke staff FTE
- Pregnancy Intention Initiative Staff FTE

Dartmouth Health | Mt. Ascutney Hospital and Health Center



* Community Health Team Patient Count (January–September, 2025—may include duplicates)
‡ Spoke Eligible Patient Population (Average July–September, 2025)

COMMUNITY PARTNER ENGAGEMENT THROUGH TEAM-BASED CARE AND OTHER ACCOMPLISHMENTS

In 2025, the Windsor Health Service Area (HSA) was home to two multi-agency community collaboratives, maintained within the Accountable Communities for Health (ACH) model. Both engaged with the Camden Coalition for the Team-Based Care (TBC) initiative. Partners included Tri-Valley Transit, designated mental health agencies, local schools, Support and Services at Home (SASH), Safeline, Council on Aging, Capstone, various divisions of the Vermont Department of Health (VDH), and the Upper Valley Public Health Council.

Discussion with community collaboratives led Little Rivers Health Care (LRHC) to host routine Women, Infants & Children (WIC) clinics in Bradford and expand their Food Pharmacy program eligibility to include perinatal patients. Sites participating in the Mental Health Integration (MHI) Pilot screened all patients for nutrition insecurity, and LRHC offered "food as medicine" options through partnerships. LRHC and Connecticut Valley Addiction Recovery maintain Spoke services for Medication for Opioid Use Disorder (MOUD), and Mt. Ascutney Hospital and Health Center (MAHHC) continues to offer rapid access to MOUD and peer recovery coaches.

Collaboration continues between medical homes and MyHealthyVT (MHVT) specialists, encouraging referrals to Vermont's self-management programs through the Community Health Team (CHT). Public service announcements about MHVT programming aired on local public television, and new in-person courses were held locally, with more planned for 2026.

> "Working in Community Health allows us to identify, address, and monitor health disparities in the Windsor HSA community. We are able to promote education, well-being, access to healthcare, and be a liaison for community resources and stakeholders. . . . The collaborations that we hold allow us to advocate for systemic change for all of our patients, colleagues, and community."
>
> —CHT Member

QUALITY IMPROVEMENT (QI) ACHIEVEMENTS

Our HSA focused on developmental screening rates and subsequent referrals for diagnosis by specialty providers. Meetings between practice staff and the QI Practice Facilitator and/or the OneCare Vermont (OCV) Quality Specialist, as well as chart reviews at multiple sites, confirmed that standardized developmental screenings had gone unbilled, resulting in low HSA-level rates provided by OCV and Blueprint.

Through creation of new visit types and order sets, training, and revised scanning processes—plus data feedback when billing codes were absent from encounters—the HSA rate increased over 20% increasing revenue for well-child care!

MAHHC providers, certified to administer the Child Autism Rating Scale (CARS2), helped reduce the timeline to connection with appropriate developmental services by an average of 18 months! An Upper Valley Pediatrics provider has also begun this certification process, and MAHHC plans to expand access to patients at Ottauquechee Health Center in 2026.

Clinical quality measure improvements remain motivated by the sustainment of Patient-Centered Medical Home (PCMH) recognition and aim to increase per-patient-per-month payments. MAHHC is committed to screening for depression "every visit, every time," focusing on real-time documentation in discrete fields, yielding a 6-point increase in performance rate. New processes to collect home blood pressure measurements were implemented, specific to patients with co-occurring hypertension and substance use disorder attending monthly MOUD visits, yielding high readings. Similarly, White River Family Practice's CHT nurse now contacts patients with hypertension, sharing packets with provider-chosen materials.

The most complex improvement effort pursued this year by OCV-participating sites was improvement on follow-up visits (within seven days) after Emergency Department (ED) visits. One organization successfully increased its performance rate by 4.9 points by increasing ED follow-up visits to clinic schedule templates.

> "Blueprint's Community Health Teams connect people to resources that address the full spectrum of health needs, from housing and food insecurity. Because we're local to the area, we understand the unique challenges Vermonters face in each community and can tailor our approach to support them effectively."
>
> —MHI Community Health Nurse

> "I explain things in whatever way and however many times is needed to ensure understanding. . . . For the younger population with increased anxiety and school avoidance, [for example], I have served as the primary care representative for new school meetings, IEP meetings, and 504 meetings. . . . Not only is this a win for the kids and myself, but [this] took a huge weight off the shoulders of the parents, allowing for them to finally take care of themselves."
>
> —CHT Member

FUTURE GOALS

In 2026, CHT staff at MAHHC plan to implement risk reduction strategies, e.g., safety kits, within primary care settings, and LRHC plans to expand in-clinic food shelves, curated by dietitians and guided by lifestyle medicine principles, with zero barriers to access. Two practices, Little Rivers Health Care and Upper Valley Pediatrics, will be moved to the Randolph Health Service Area in 2026 because they are located in Orange County and share many of the same community partners as the PCMHs affiliated with Gifford Medical Center.

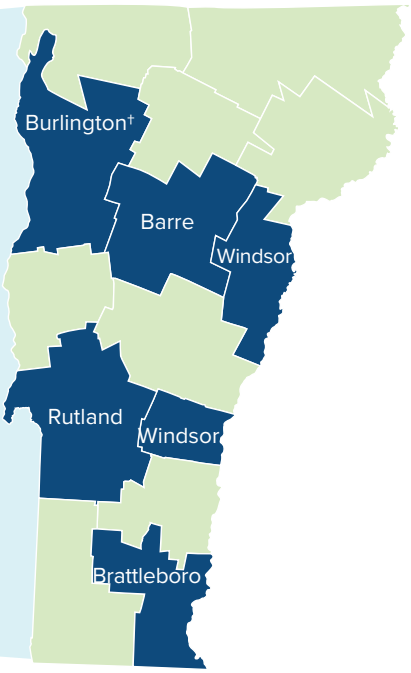
PLANNED PARENTHOOD OF NORTHERN NEW ENGLAND (PPNNE) HEALTH SERVICE AREA

Program Manager: Rey Francois

At a Glance

5,926	Attributed Patients Statewide
1,514	CHT Encounters
2.3	Pregnancy Intention Initiative Staff FTE

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



COMMUNITY PARTNER ENGAGEMENT THROUGH TEAM-BASED CARE AND OTHER ACCOMPLISHMENTS

The Planned Parenthood Highlights report serves as an annual summary of progress for our community and for the legislators who support our work. This report provides an accessible overview of key accomplishments in 2025, focusing on the ways team-based care and collaborative partnerships have contributed to better health outcomes and patient experiences in our region. By presenting these highlights, we aim to inform, inspire, and encourage continued investment in community-driven health care solutions.

Throughout 2025, PPNNE has made significant strides in engaging community partners across all health care settings. Team-Based Care, an approach where health professionals from various disciplines work together, has been at the heart of this progress. By leveraging the unique strengths of each partner, hospitals, primary care, behavioral health, and community organizations, we have created a more connected and supportive environment for patients and families.

A key driver of this engagement has been the leadership provided by our Patient Support Counselors (PSC). Their efforts have re-energized longstanding partnerships and fostered new collaborations. This renewed energy has allowed us to break down silos and share resources more effectively, ensuring that patients receive consistent, high-quality care regardless of where they enter the health system. This has included our PSCs working closely with Vermont Chronic Cair Initiative (VCCI) to support our patients needing more complex, ongoing medical and systems support that can meet them based in their homes and communities.

One of the most notable achievements in 2025 has been our continued focus on patient experience and access through regular feedback from our patients through a survey. We have listened to the voices of those we serve. As a result, we continue to practice trauma-informed care at all our health centers. Our PSC have created partnerships across the staff, allowing us to strengthen care coordination, allowing patients to access needed services and feel supported throughout their care journey.

> "By no exaggeration, the services provided through Patient Support Counseling is life-saving work. I have shared the resources I was made aware of through this service with friends, and the instant relief is visible. Not only does this kind of support help individuals, but it also aids in building stronger communities and mutual aid. Thank you."
>
> —Patient

Additionally, our PSC has seen success in expanding preventive care initiatives and supporting at-risk populations. Partnerships with Blueprint staff helped us address Social Drivers of Health (SDOH), such as food security and housing stability, further strengthening the fabric of our community. This has included work ranging from directing patients to their local food banks, enrolling in SNAP, and connecting to overnight shelters, to supporting our patients with more complex needs in connecting with Vermont Legal Aid for complex needs around losing housing, accessing healthcare, and accessing support for their disability.

QUALITY IMPROVEMENT (QI) ACHIEVEMENTS

Quality improvement has remained a top priority for PPNNE in 2025. The continued partnership with the Blueprint QI Facilitator has enabled us to base our efforts on evidence and measurable outcomes. By analyzing these data sets, care teams have identified gaps in care, tracked progress, and set clear targets for improvement.

One of the standout examples of data-driven improvement is our initiative to increase and standardize screening rates. By pinpointing geographic areas with lower rates, care teams developed targeted outreach campaigns, workflow trainings, and partnered with health center leadership to reduce barriers to screening. We are actively engaged in this improvement project and will reevaluate it in 30, 60, 90 days.

FUTURE GOALS

In summary, 2025 has been a year of renewed collaboration, innovation, and measurable progress within our HSA. The emphasis on Team-Based Care and the strategic use of Blueprint partnerships have also strengthened our community partnerships and patient relationships. Looking ahead, we remain committed to building on this momentum, exploring new ways to support our community's well-being, and ensuring that our health centers continue to adapt and thrive.

APPENDIX 1: EVALUATION MEASURE RESULTS

The charts on the following pages display data from 2019 to 2023 for various healthcare quality measures reported in the Vermont Health Care Uniform Reporting and Evaluation System (VHCURES), Vermont's all payer claims database. These measures provide an overview of health utilization trends in Vermont on a statewide level for the Blueprint PCMH attributed population.

Specifications for measures may have changed from previous Annual Reports as national specifications are updated regularly. 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. Providers, quality improvement facilitators, and field staff work together to identify the underlying causes of the change and implement interventions to achieve the desired outcomes.

To provide more meaningful and focused information, the number of measures displayed below has been reduced in comparison to previous years. The remaining measures were kept because they address Blueprint's legislative requirements and help measure the impact of the Blueprint. Measures included in the previous annual report can still be found in the Blueprint Community Health Profiles on the Blueprint for Health website. Additionally, all charts only display information on the population that is attributed to Blueprint PCMH primary care practices, to provide more accurate information on program impact.

Target rates are shown on the charts for each measure. Where possible, these target rates are based on HEDIS national averages found under NCQA's State of Health Care Quality Report, or on targets set by the Vermont Department of Health (VDH). If those target rates were not available, the target is set at the average rate for the measure from 2019 to 2023. The average is chosen since the Blueprint is an established program and, for many measures, the goal is to sustain improvements.

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

CHARTS

Expenditures Total Per Member Per Year

Blueprint PCMH Primary Care Attributed Population

Developmental Screening in First Three Years of Life

Blueprint PCMH Primary Care Attributed Population

Child and Adolescent Well-Care Visits 12–17

Blueprint PCMH Primary Care Attributed Population

Hypertension with BP in Control

Blueprint PCMH Primary Care Attributed Population

Diabetes HbA1c Not in Control

Blueprint PCMH Primary Care Attributed Population

Asthma Medication Ratio (AMR) of Controller Meds to Total Asthma Meds of 0.50 or Greater

Blueprint PCMH Primary Care Attributed Population

COPD & Asthma Admissions, 40y+

Blueprint PCMH Primary Care Attributed Population

Heart Failure Admissions

Blueprint PCMH Primary Care Attributed Population

Cervical Cancer Screening

Blueprint PCMH Primary Care Attributed Population

Chlamydia Screening in Women 16–24

Blueprint PCMH Primary Care Attributed Population

Child and Adolescent Well-Care Visits 3–21

Blueprint PCMH Primary Care Attributed PopulationChild and Adolescent Well-Care Visits 12–17

Blueprint PCMH Primary Care Attributed Population

Outpatient ED Visits /1000 Member Years

Blueprint PCMH Primary Care Attributed Population

TOTAL VHCURES (EXCLUDING SELF-INSURED) POPULATION

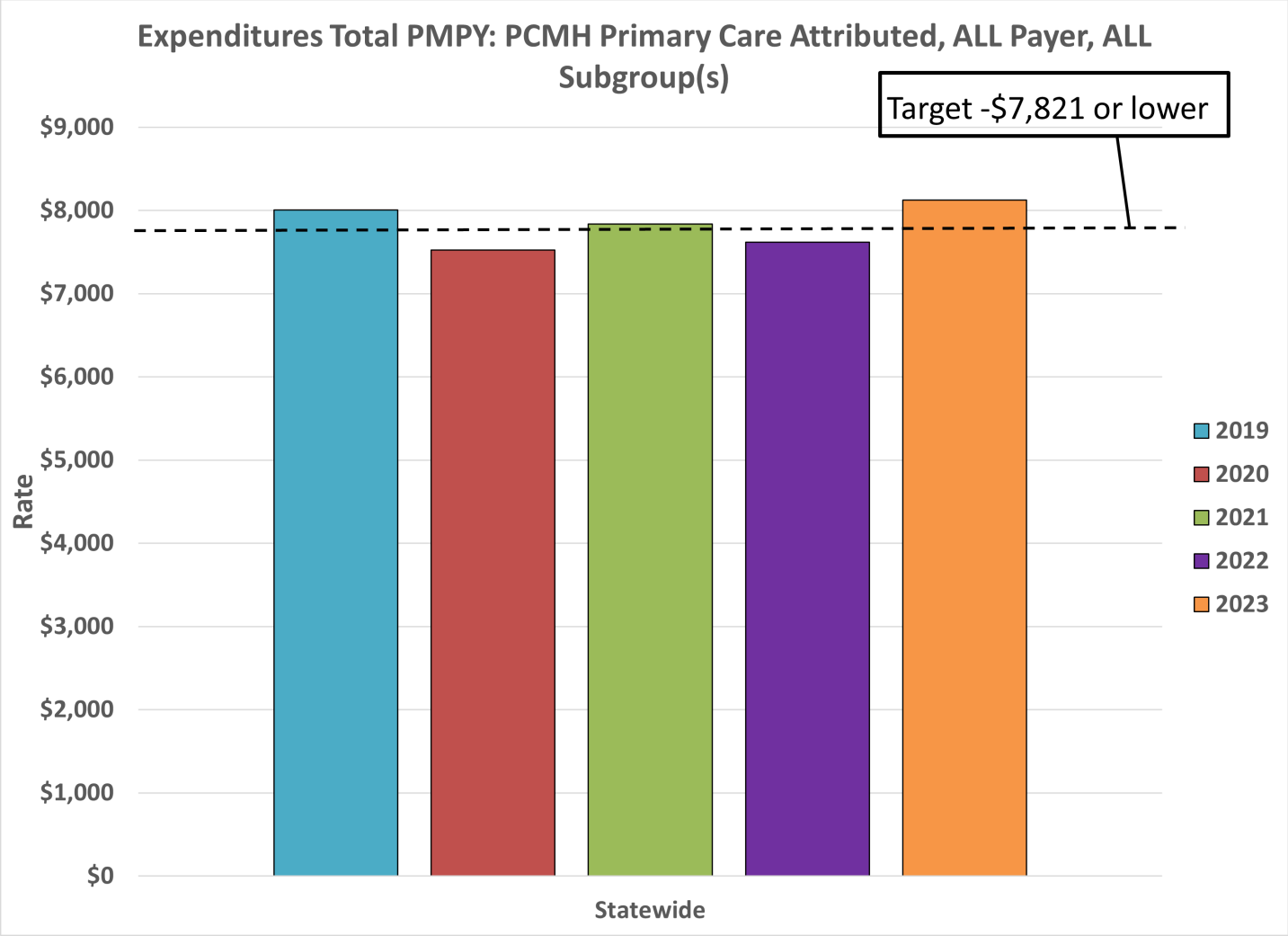


Chart 1 displays the total expenditures per member per year, reported as an inflation-adjusted and risk-adjusted per member per year (PMPY) rate by Hospital Service Area. In practical terms, this chart shows how much the total claims amount is per person per year in Vermont. Please note that the amounts displayed are not necessarily the amount paid by any individual Vermonter. The target rate is the average rate for this measure from 2019 to 2023. Currently the target rate is not being met, and the Blueprint will investigate.

DEVELOPMENTAL SCREENING IN FIRST THREE YEARS OF LIFE

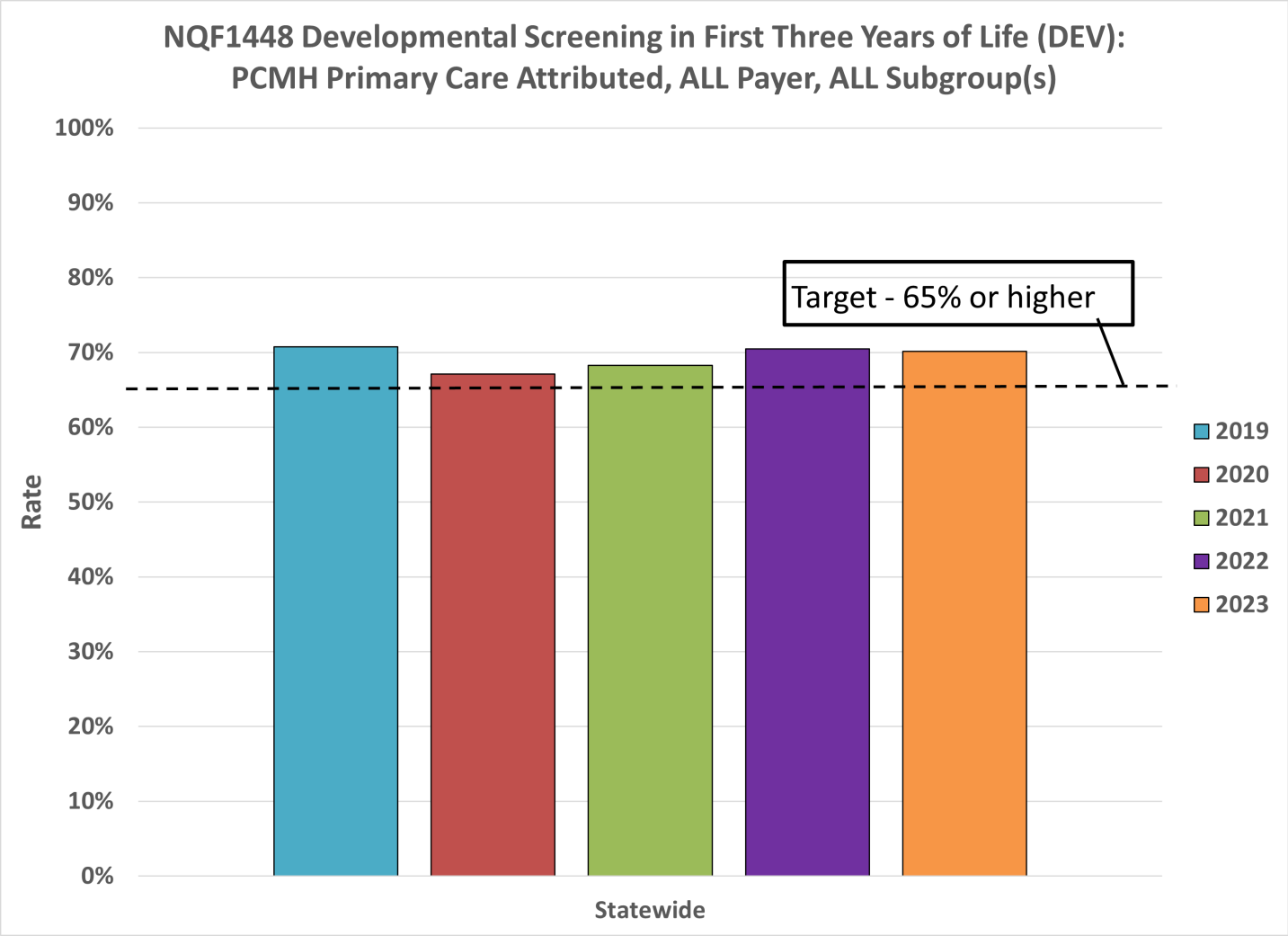


Chart 2 displays the percentage of children aged 3 or less, who were screened for risk of developmental, behavioral, and social delays by the age of three by Hospital Service Area. This target rate is based on targets set by VDH and is currently being met.

CHILD AND ADOLESCENT WELL-CARE VISITS 12–17

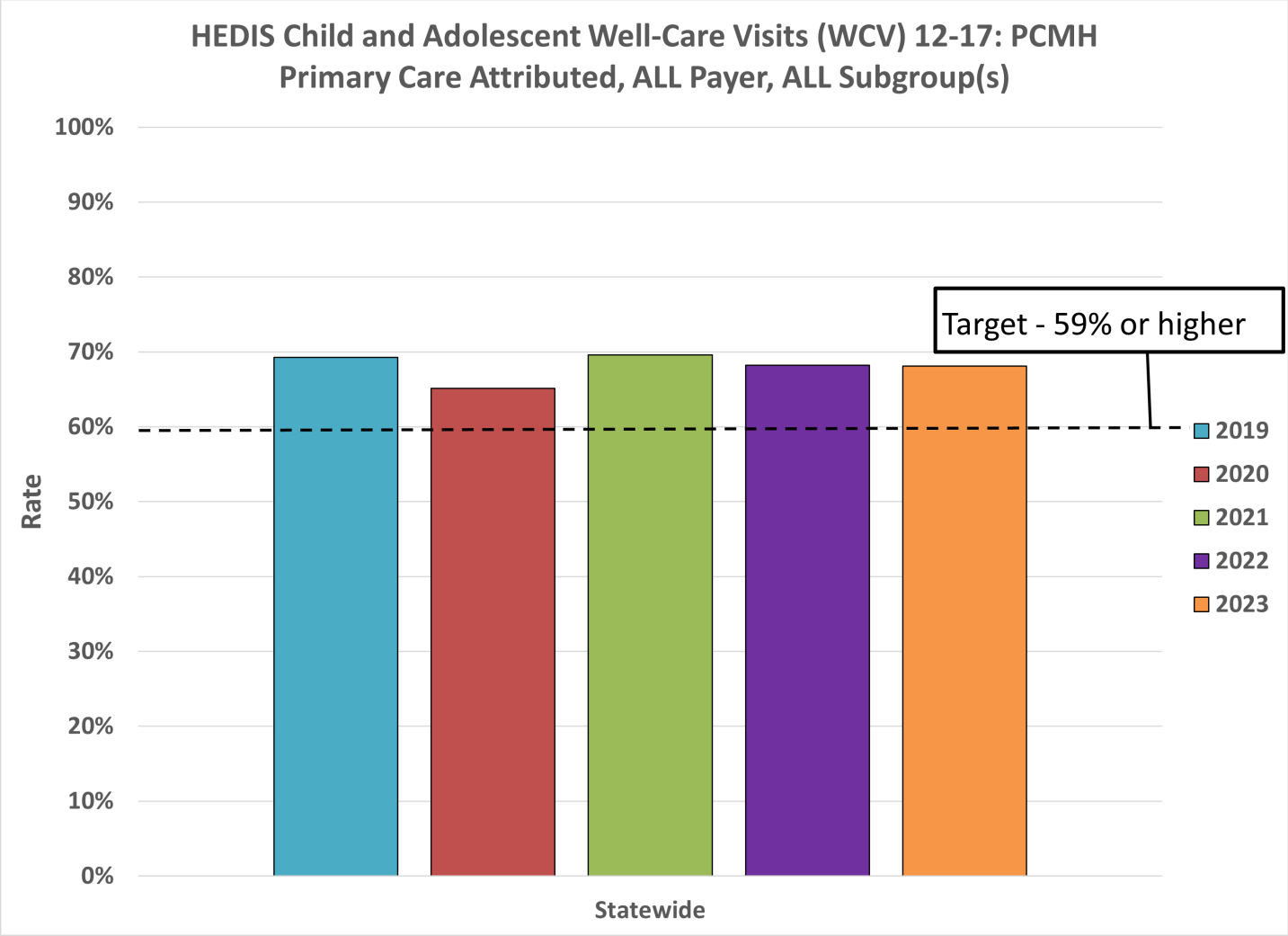


Chart 3 displays the percentage of adolescents 12–17 years old who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year by Hospital Service Area. This target rate is based on targets set by (VDH) and is currently being met.

HYPERTENSION WITH BP IN CONTROL (<140/90 MMHG)

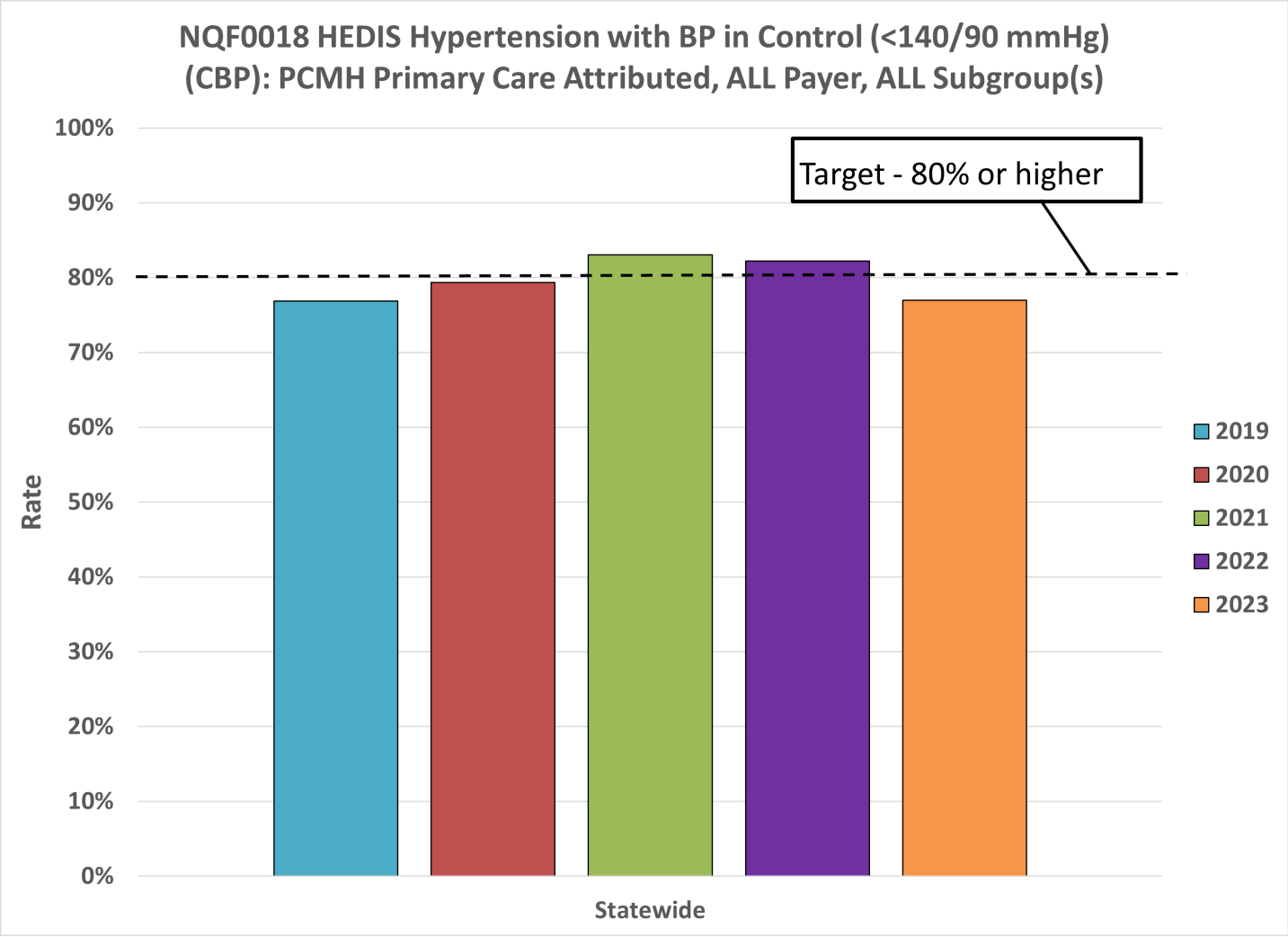


Chart 4 displays rates of Blueprint PCMH-attributed patients with hypertension who have blood pressure less than 140/90 mmHg by Hospital Service Area. The target rate is the average rate for this measure from 2019 to 2023. It is not currently being met, and the Blueprint will investigate.

DIABETES HBA1C NOT IN CONTROL (>9%)

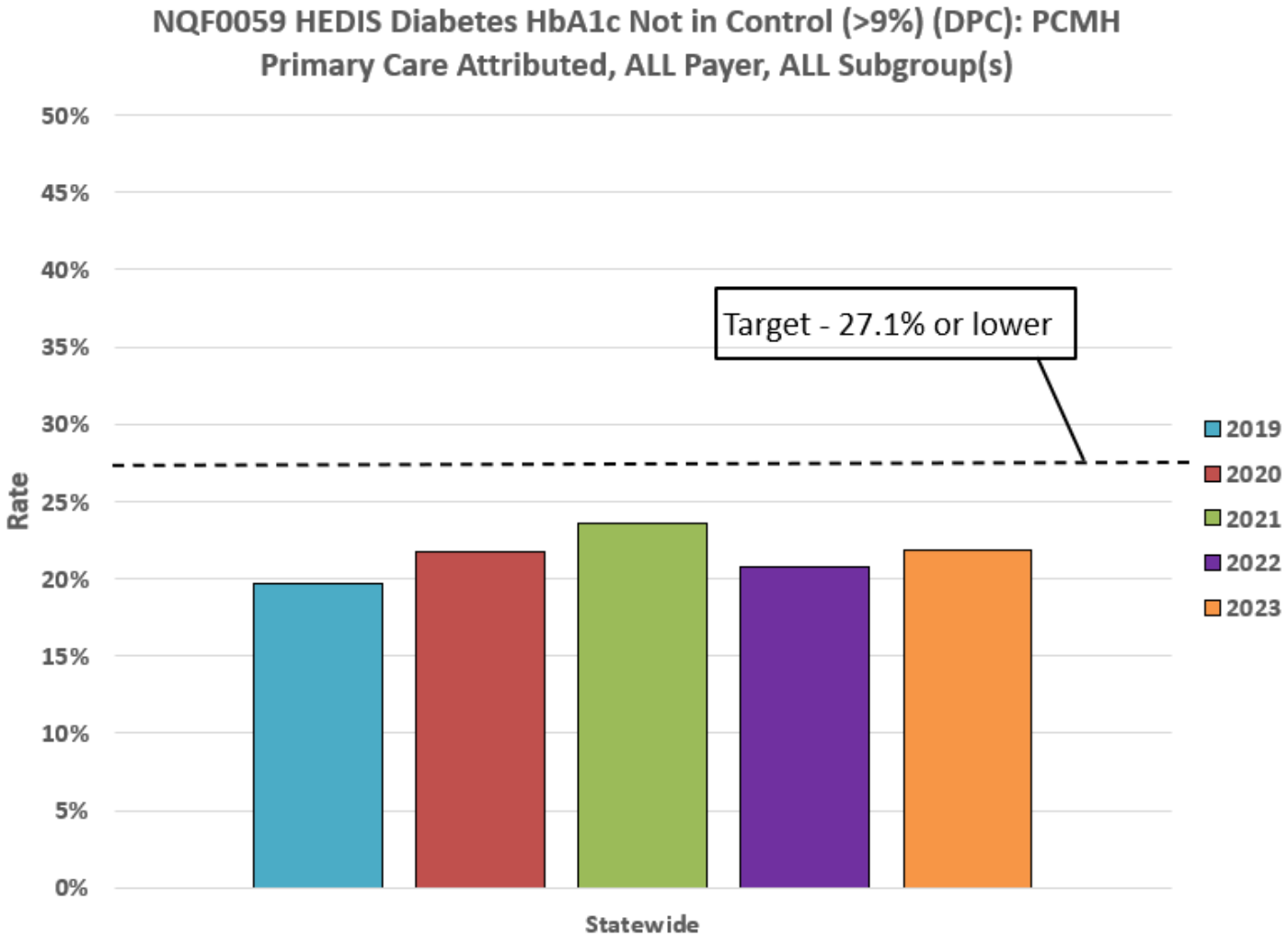


Chart 5 displays the statewide rates of Blueprint PCMH-attributed patients whose diabetes HbA1c percentage is higher than 9%. For this measure, lower rates are better. The target rate is based on HEDIS national averages. Currently this target rate is met.

ASTHMA MEDICATION RATIO (AMR) OF CONTROLLER MEDS TO TOTAL ASTHMA MEDS OF 0.50 OR GREATER

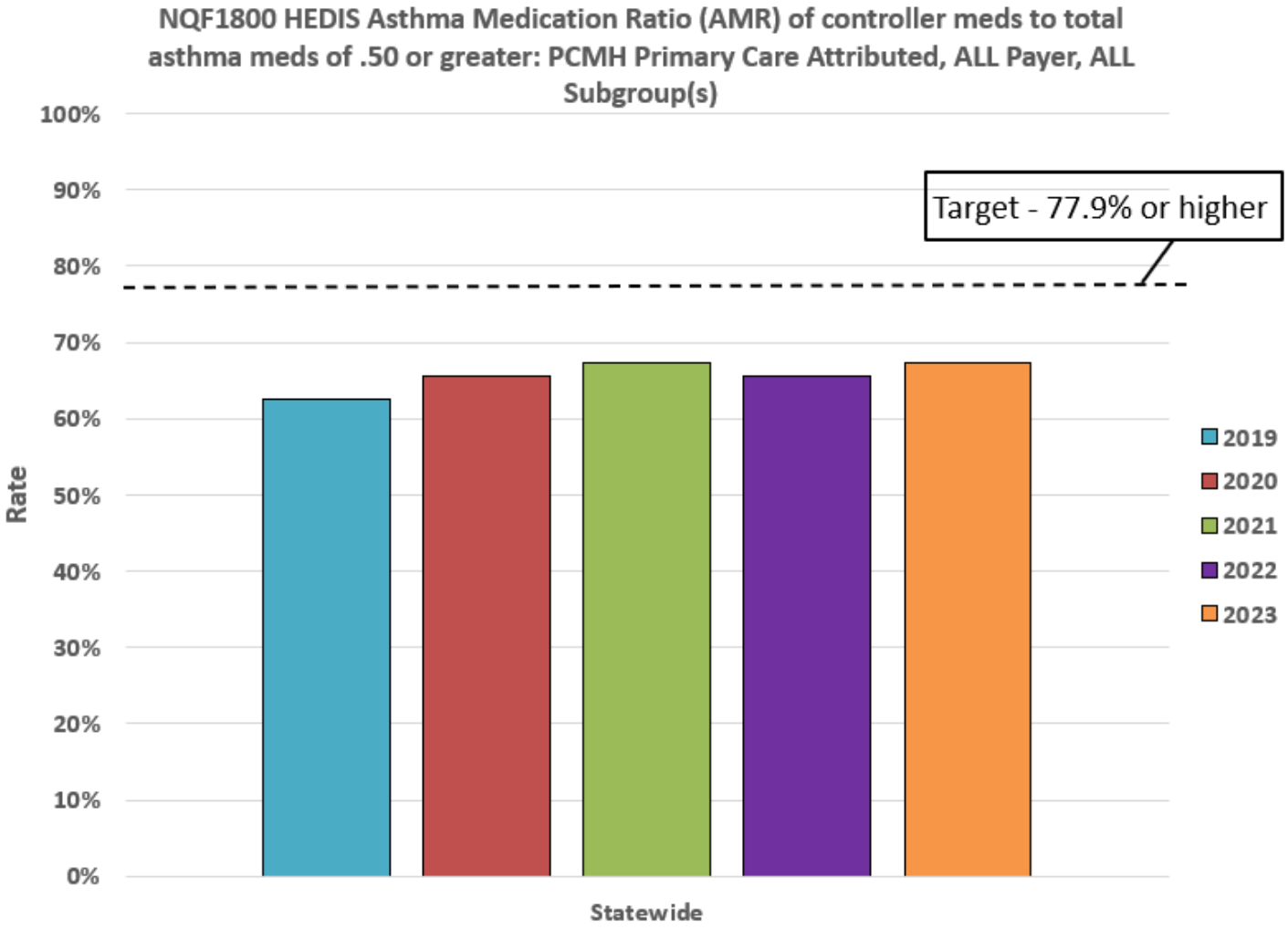


Chart 6 displays the statewide rates of the Blueprint PCMH-attributed population 5–64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year by Hospital Service Area. The target for this rate is based on HEDIS national averages. It is currently not being met, and the Blueprint will investigate.

COPD AND ASTHMA ADMISSIONS, 40Y+

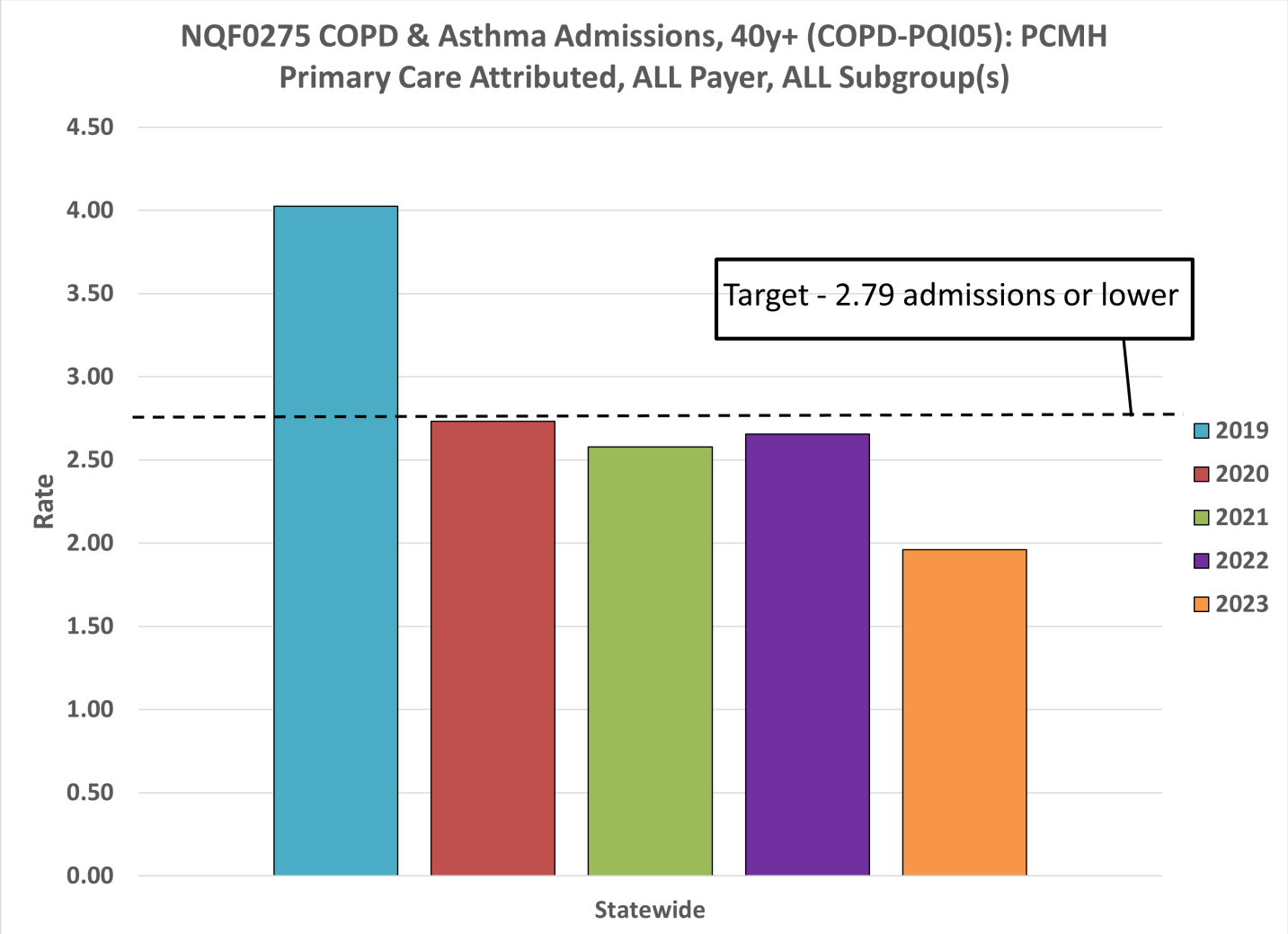


Chart 7 displays hospitalizations with a principal diagnosis of chronic obstructive pulmonary disease (COPD) or asthma per 100,000 people ages 40 years and older for the Blueprint PCMH-attributed population. Excludes hospitalizations with cystic fibrosis and anomalies of the respiratory system, obstetric hospitalizations, and transfers from other institutions. The target rate is the average rate for this measure from 2019 to 2023 and is currently being met.

HEART FAILURE ADMISSIONS

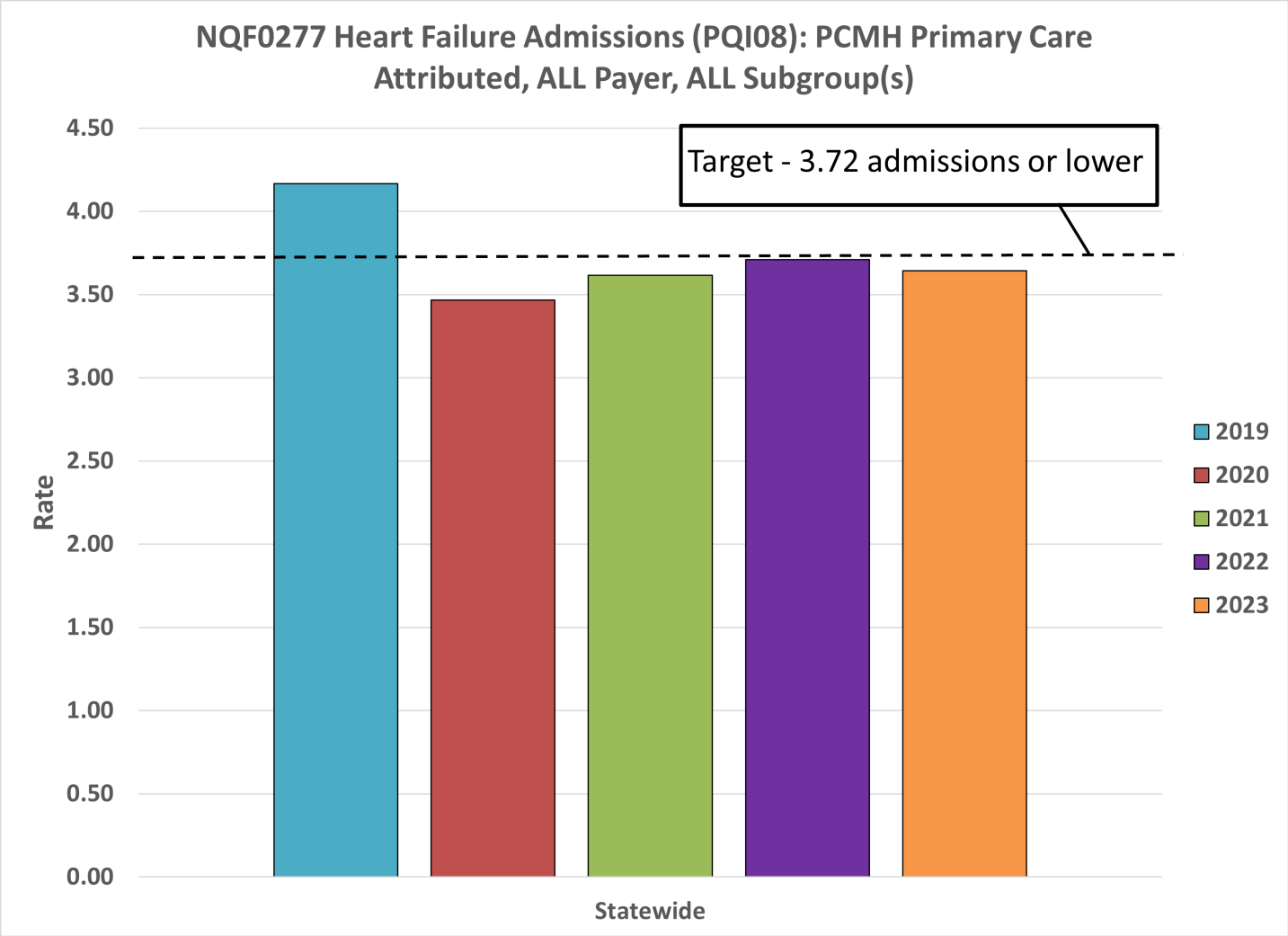


Chart 8 displays hospitalizations with a principal diagnosis of heart failure per 100,000 population, ages 18 years and older for the Blueprint PCMH-attributed population. Excludes hospitalizations with cardiac procedure, obstetric hospitalizations, and transfers from other institutions. The target rate is the average rate for this measure from 2019 to 2023, and is currently being met.

CERVICAL CANCER SCREENING

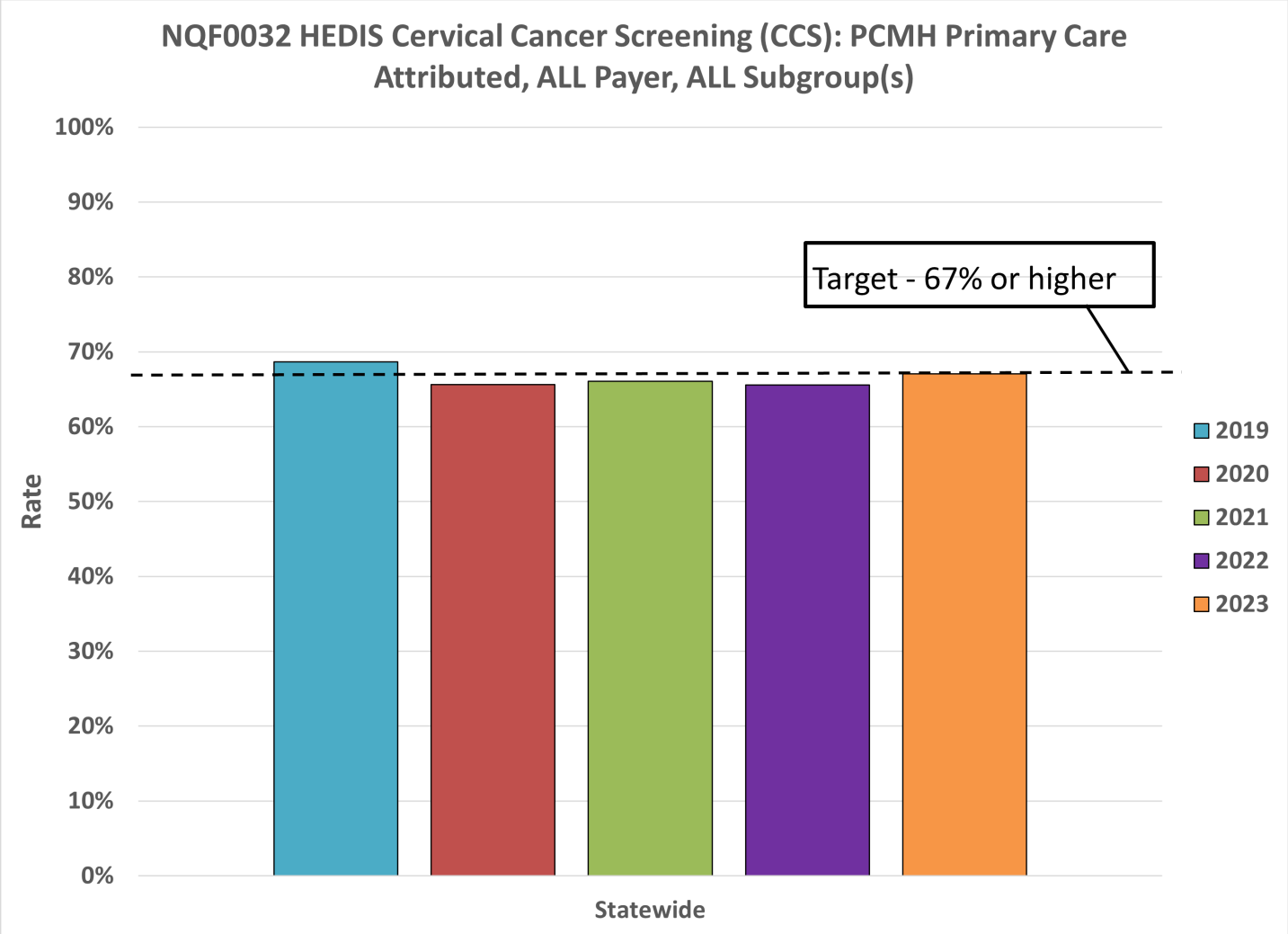


Chart 9 displays the percentage of women 21–64 years of age who were screened for cervical cancer using any of the following criteria by Hospital Service Area:

- 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.

The target rate is the average rate for this measure from 2019 to 2023, and currently is being met.

CHLAMYDIA SCREENING IN WOMEN 16–24

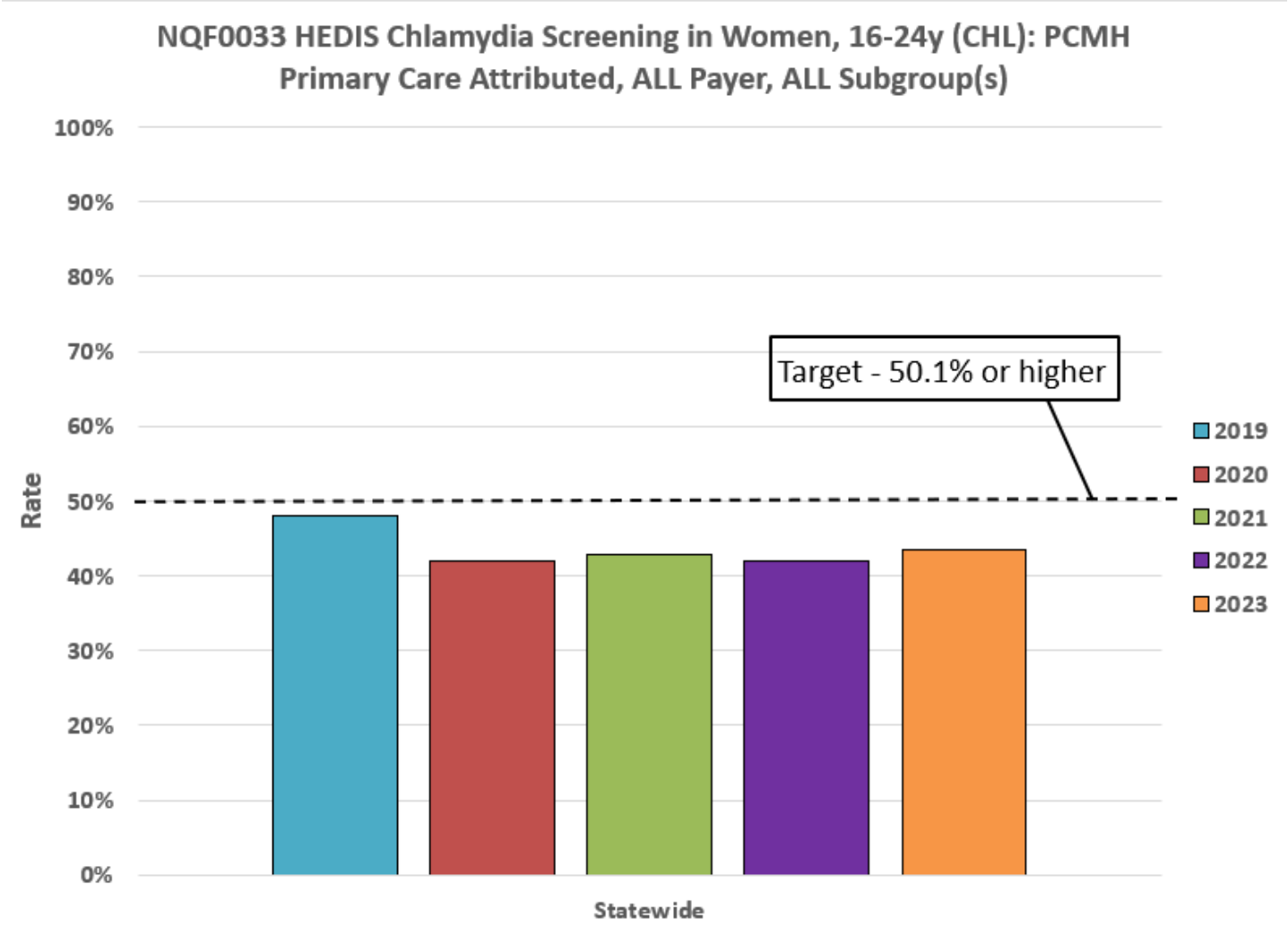


Chart 10 displays the percentage of women 16–24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year. The target for this rate is based on HEDIS national averages. It is currently not being met, and the Blueprint will investigate.

CHILD AND ADOLESCENT WELL-CARE VISITS 3–21

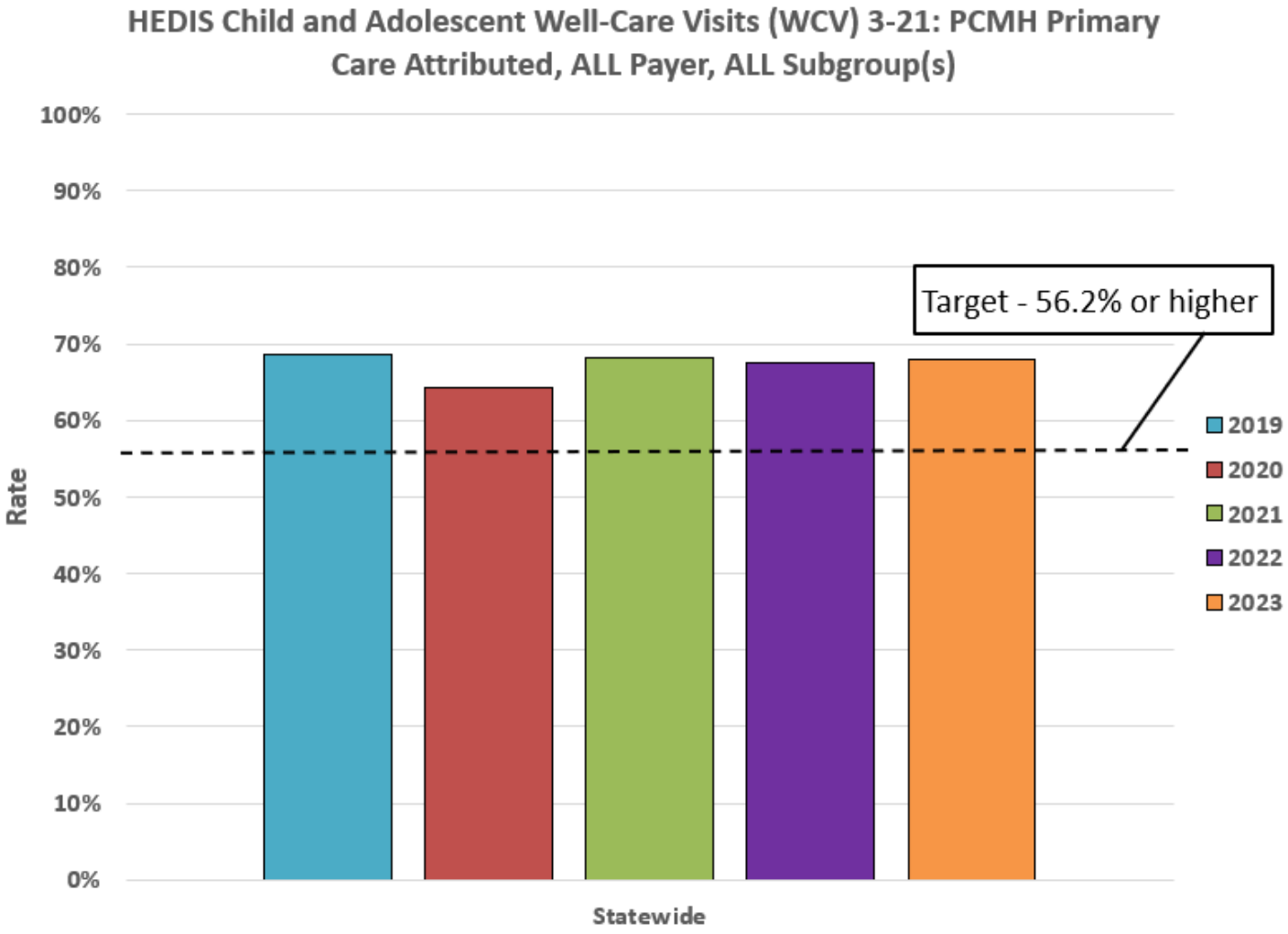


Chart 11 displays the percentage of adolescents 3–21 years old who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year. The target for this rate is based on HEDIS national averages, and it is currently being met.

OUTPATIENT ED VISITS/1000 MEMBER YEARS

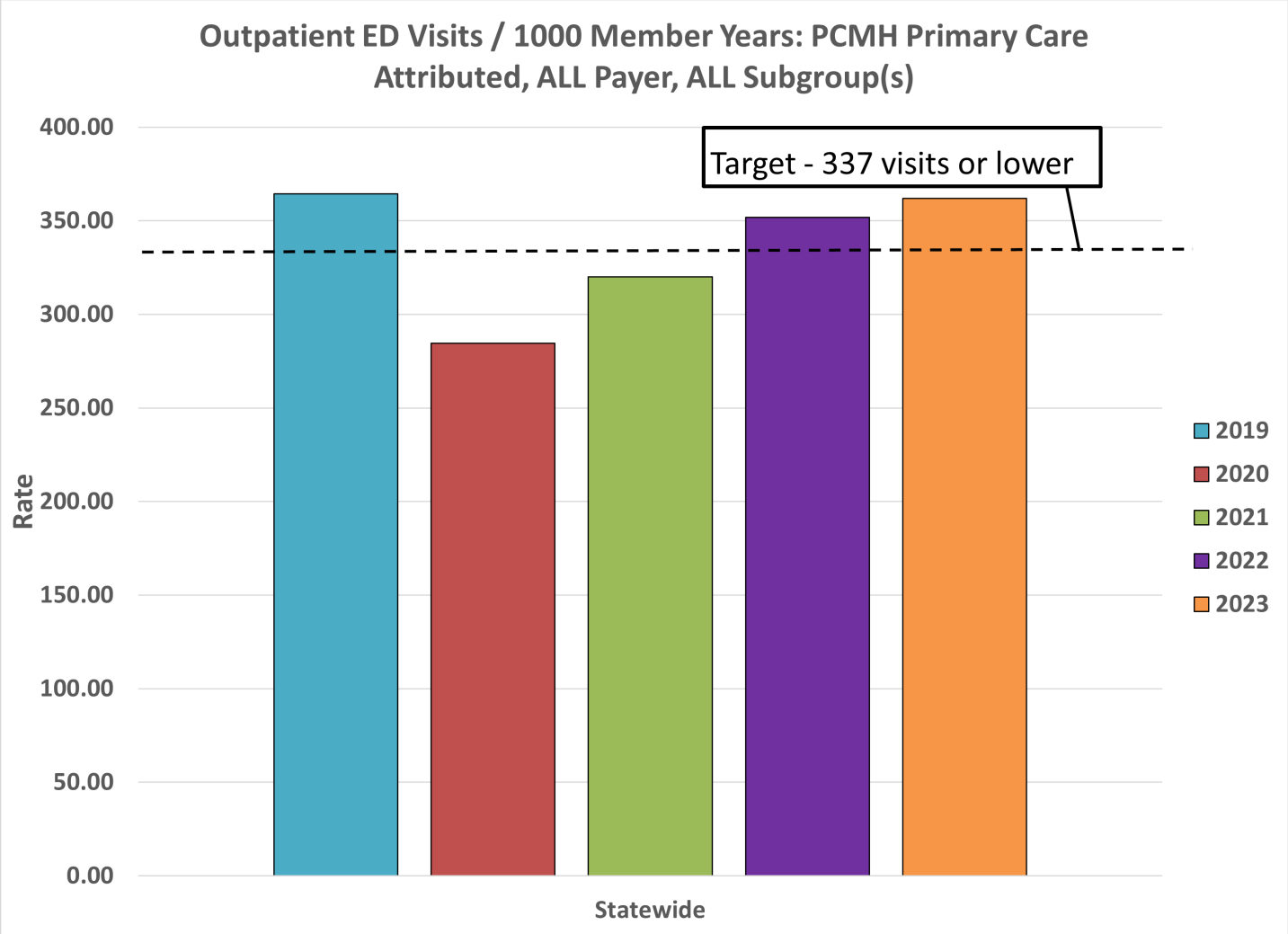


Chart 12 displays the risk-adjusted rate of outpatient emergency department visits per 1000 member-years. The target rate is the average rate for this measure from 2019 to 2023. It is currently not being met, and the Blueprint will investigate.

Year in Review

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2025

Community Health Team

Total CHT FTE:

247.42

Core: 113.85

Spoke: 59.6

PII: 10.30

MHI: 63.67

Team Based Care:

Adding TBC goals in each ACH

Team-Based Care online trainings

Steering Committee participation

Primary Care Technical Assistance

MHI Expansion Evaluation

Department of Health MOUs

Division of Substance Use program collaboration
$184,983

Self-Management, Vermont Department of Health:
$664,163

Financial Oversight

Total Program Impact: ~$42M

~$29.4M in Core CHT, PCMH, PII, Spoke payments

~$6.8M in MHI

~$4.8M in programmatic funds (grants, contracts, self-management, analytics) of which ~$1.5 is PMs/ grants, and $1.2M is analytics contracts

Operations at about $3.5M (~8% administrative overhead, analytics contracts, Program Managers)

In total, **Blueprint for Health-**supported initiatives and services impact

up to **80%**

of Vermont's population

Blueprint For Health Central Office Current Team Composition

Executive Director

Blueprint Assistant Directors (2)

Health Services Researcher

Payment Operations Administrator

Data Analytics and Information Administrator

Project Administrator

Statewide QI Coordinator

Physician Clinical Consultant

Dartmouth Preventive Medicine Leadership Residents

Practice participation

124 primary care offices/PCMHs

24 MOUD specialty sites (90 Spokes in total)

18 PII specialty sites (one new this year)

14 Health Service Area Administrative Grants

14 Program Managers

8 CHT Leaders

12 QI professionals

2 in-person field staff leadership meetings

ALSO . . .

Maintained **Executive Committee** composition with multiple new members including commercial insurer, consumer, nurse practitioner and self-insured employer.

One in-person Executive Committee meeting

CMS approval of Blueprint preprint (payments) through 2027, aligned with making changes in 2028 to performance payments

Extensive testing of MDWAS

eCQM analysis for 2025—anticipate Field Staff entry into portal in 2026

Quarterly reporting of progress

Suicide Prevention Work with DMH and VPQH to assist with **Zero Suicide** with Primary care

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

2025 Quality Measure Crosswalk

QI Monthly Meeting Topics/Trainings:

2025 PCMH Standards
Lead Screening
PCMH Care Plans
CAHPS
MHI Expansion Chart Review Analysis

Suicide Mini Grants
SDOH Screening
Practice Summaries and Community Health Profiles
HRSA/UDS Quality Measures
Medicare Annual Well Visits
eCQM Data Collection
Blueprint Performance Payments
VITL-VCHIP Pediatric Shared Plans of Care
Diabetes Strategic Plan
AHA/ACC HTN 2025 Guidelines
MIPS
PCMH Care Planning

next page »

Major Accomplishments 2025

- **Strategic Plan** including Mission, Vision, Values
- Switch of administrative entity to Copley Hospital from LHP | SIU reporting and f/u support to DHVA for LHP misuse of CHT and MHI funding
- Change of Little Rivers and Upper Valley Pediatrics to Randolph Health Service Area for greater alignment with county lines (they are now in Orange County rather than Windsor).
- Significant updates to the *Blueprint Manual* in 2024 and 2025
- Convened **Vermont Steering Committee for Comprehensive Primary Health Care**, providing technical and administrative support to main committee and sub-committee, including three committee meetings and one sub-committee meeting in 2025.
- VCCI collaboration for quarterly access report and Practice Access to Care input incorporated into Blueprint portal
- **Extended MHI funding for another year past the pilot**.
- Significant involvement in Health Transformation, including organizing and supporting **Regional and Hospital Meetings**, including Acuity, Capacity, and Inter-facility Transportation, Services lines
- State auditor report and exit conference completed.

Additional Projects

- Collaboration with DAIL on **community nursing**
- Dr. Addie Armstrong completed VAHLSA and is now mentoring
- Gainwell re-write of process for keeping current with Patient-centered medical homes
- **Complementary Medicine learning collaboratives**
- **WORKFLOW GUIDES FOR DEPRESSION AND HYPERTENSION**
- Performance Payment enhancement exploration
- Abstract presentations at IHI in Orlando and Preventive Medicine in Seattle
- Updating of Hub and Spoke State Plan Amendment: LNAs will no longer need a waiver, and master's-prepared unlicensed will no longer need a waiver
- **HTN collaborative VDH, BP, OCV**
- Alzheimer's project with DAIL and Alzheimer's Association for impact on primary care
- Quarterly Maternal Health meetings to inform on overlapping areas, goals, and planning some future trainings for PII and home visiting program

Education and Training

In 2025, the Blueprint completed an intensive training program through the **Mental Health Integration** initiative, providing

37 trainings over a 12-month period.

A total of **1,096 people** attended trainings

in Motivational Interviewing (73), Structural Competence and Cultural Humility (62), Community Health Workers in a Primary Care Setting (19), Foundations for Community Health Worker Supervision and Support (15), Bridges Out of Poverty (62), Working with 2SLGBTQ+ Peoples (160), and a series of 12 pediatric trainings held in partnership with Developmental Understanding and Legal Collaboration for Everyone (DULCE) (686).

The central office also engaged 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**. The team-based care curriculum is now available on the Blueprint learning management system.

Conferences attended or invited as presenter: Bi-State, VMS conference(s), VAHHS, Preventive Medicine, Vaccine Rate Setting meetings, Digital Therapeutics, Vermont Business Roundtable, MDWAS, Every Day Counts, VDHIP conference, Digital State Government conference, Health Equity Summit

CARE series: Five webinars featured nationally recognized presenters on innovative, patient-centered topics such as prescription digital therapeutics, culturally responsive care, and integration of traditional medicine into care. Six virtual workshops featured Vermont experts who provide primary care based mental health and substance use care, substance use treatment during pregnancy, support for patients experiencing gender-based violence, or oral health care in the context of substance use. An average of 77 Vermont care-team members and affiliated service providers attended each virtual event. There were **141 attendees** to the Community Collaboration for Mental Health & Substance Use Disorder Treatment and Recovery conference with **every Health Service Area** represented.

18 Lunch and Learns for CY 2025

2 LARC trainings: 26 participants
(Federal regulations only allow 13 per training.)

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