REPORT TO THE VERMONT LEGISLATURE

Agency of Human Services

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Annual Report on Blueprint for Health

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

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

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Secretary

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Executive Director

Report Date: January 31, 2023

It's the Agency of Human Services' mission to improve the conditions and well-being of Vermonters and protect those who cannot protect themselves.

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I. EXECUTIVE SUMMARY

Legislation & Report Contents

18 V.S.A. § 709. requires the Blueprint for Health (Blueprint) to make an annual report to the legislature:

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

The Vermont Blueprint for Health (Blueprint) was established to promote high quality primary care that is integrated with services outside of the medical setting that impact 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 and in the community. Essential to the success of the PCMHs and CHTs is a network of locally hired Program Managers, Community Health Team Leaders, and Quality Improvement Facilitators. This network has been integral to facilitating local transformations and increasing collaboration across community partners.

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

In 2022, Dr. John Saroyan joined the Blueprint as the Executive Director and spent much of 2022 assessing the needs of the program and designing plans for future objectives. As

part of this work, the Blueprint team worked to revitalize and restore the Executive Committee to better meet its statutory requirements. The Blueprint Executive Committee is currently complete with assigned members representing each of the required stakeholders. Additionally, Dr. Saroyan and the Assistant Directors embarked upon an all-state tour.

Blueprint is poised now to serve once again as Vermont's key health care innovation engine. In responding to Act 167 (2022), Blueprint proposed expanding the Community Health Teams to integrate mental health and substance use screening, brief intervention and treatment fully into Blueprint practices. This concept is supported by the Mental Health Integration Council, and is a concrete step in a critical clinical practice change identified by Vermont patients and providers.

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. Three practices achieved a new transformation into a Patient-Centered Medical Home in 2022. Each of these existing practices changed organizational affiliation or had a substantial enough change in location, population served, or providers employed to require that they were required to undergo the full review process with NCQA. Additionally, 129 practices sustained recognition as a Patient-Centered Medical Home in 2022 by attesting that they meet the core requirements and providing additional evidence required for annual reporting.

Community Health Teams

Along with the Patient-Centered Medical Home model, Community Health Teams are integral to the success of the Blueprint. These teams, funded by commercial and public payers, provide services to patients that are not generally covered by insurance. Services can include care coordination, social work, brief mental health interventions, referrals to services, and numerous other interventions, free of charge and without regard to insurance status. Currently, there are a total of 177 staff (118 FTEs) working as members of the Community Health Teams 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.

During 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.

Hub and Spoke

Hub & Spoke is Vermont's system of medication for opioid use disorder (MOUD) supporting people in recovery from opioid use disorder. The Blueprint administers the Spoke part of the Hub & Spoke system. Vermont continues to demonstrate substantial access to medication-assisted treatment for Vermonters with opioid use disorder registered nurses, and licensed, Master's-prepared, mental health/substance use disorder clinicians as a team to offer evidence-based treatment and provide Health Home services for Vermonters with opioid use disorder. The Blueprint contract with Dartmouth College provides learning sessions with expert-led, peer-supported training in best practices for providing team-and evidence-based medication-assisted treatment for opioid use disorder. Five webinars, three virtual workshops, and a virtual conference were held from January through October of 2022. Sessions alternated between didactic care management webinars and multidisciplinary care management workshops.

Women's Health Initiative

The Women's Health Initiative (WHI) strives to support any persons who can become pregnant in their efforts to experience healthy pregnancies, avoid unintended pregnancies, and build thriving families. The WHI provides increased mental health and social service staffing at specialty practices and utilizes the existing CHT at Blueprint PCMH practices. If a patient identifies as at-risk, they have access to a mental health clinician for brief interventions, counseling, and navigation to community-based services and treatment as needed. The Blueprint reinstated in-person trainings to support the WHI network of providers in contraceptive care. In collaboration with University of Vermont, the Blueprint has supported the training of more than 50 providers from WHI sites in long-acting reversible contraception insertion (LARC) and best practices around patient choice in the past year.

Self-Management Programming

After several years of analysis and discussions, the Blueprint and the Vermont Department of Health entered into a Memorandum of Understanding (MOU) to work more closely together for the provision of Self-Management Programming. While the Blueprint still provides the funding and oversight, the Health Promotion and Disease Prevention (HPDP) unit within the Department of Health administers the programs through grants to local hospitals and Federally Qualified Health Centers (FQHCs). This partnership takes advantage of the additional funding and content expertise that exists within HPDP, and pairs it with the Blueprint's influence at the local level. Health Service Areas offered six types of Self-Management Programs during 2022:

- Blood Pressure Management
- Chronic Disease Management
- Chronic Pain Management

- Diabetes Self-Management Program
- Diabetes Prevention Program
- Quit Smoking

From October 2021 through September 2022, the Department of Health and the Blueprint saw an increase in participation in Self-Management Programming overall. There were 122 workshops offered, with a total of 538 individuals completing a program. This is a 14% increase from the previous grant year, during which 471 individuals completed a program. The Diabetes Prevention Program and the Blood Pressure Management Program had the largest numbers of workshop completers.

Evaluation

Due to the CY 2020 COVID-19 pandemic lockdowns' effects on healthcare utilization, Blueprint patient-attribution and healthcare measurement data for CY 2020 is unprecedented and not comparable to data for other years. Blueprint population-health evaluation measure results for calendar year (CY) 2020, as compared to CY 2019, show widespread and, in some cases, dramatic decreases in healthcare expenditures, utilization, monitoring, preventative services, and/or desirable outcomes. These shifts in measurement results coincide with a time period in which patients were reluctant or unable to access in-person care, and in which the healthcare system in Vermont was overwhelmed, struggling to maintain adequate staffing, and struggling to make a rapid transition to telemedicine and other remote services.

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

A full report including the survey questions for each composite above and results from the 2021 patient experience survey is available at:

Patient Experience: 2021 Consumer Assessment of Healthcare Providers Survey (CAHPS) Results (vermont.gov)

Health Service Areas

The Blueprint staff in each Health Service Area are responsible for the continued success

of the program and have worked during 2022 to move beyond pandemic response 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 impact 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[1] and bolstered by multi-disciplinary Community Health Teams (CHTs) that provide care coordination and linkages to services across the care continuum. Essential to the success of the PCMHs and CHTs is a network of locally hired Program Managers, Community Health Team Leaders, and Quality Improvement Facilitators. This network has been integral to facilitating local transformations and increasing collaboration across community partners[2].

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

While the program has evolved beyond the original "chronic care management plan" described in legislation, it remains true to the original vision of all-payer supported, community-directed health reform that promotes the health of all Vermonters. This report describes the activities and progress of the Blueprint during 2022.

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. During 2022, the Blueprint team worked to revitalize and restore the Executive Committee to better meet its statutory requirements. The Blueprint Executive Committee is currently complete with assigned members representing each of the required stakeholders. The committee met five times during 2022 and will meet six times in 2023, providing guidance and input for all Blueprint proposals and analyses. The minutes and materials for each meeting can be found here.

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[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

[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.

B. Site visits

Annual site visits to the Health Service Areas were a long-standing practice of the Executive and Assistant Directors and Blueprint staff prior to the COVID-19 pandemic. Dr. Saroyan and the Assistant Directors embarked upon an all-state tour with Bennington in May, Morrisville in June, Barre and Randolph in August, Windsor, St. Albans, Rutland in September, St. Johnsbury, Brattleboro, Newport in October, Burlington in November, and Middlebury in December. Due to illness, the Planned Parenthood of Northern New England site visit was converted to virtual meeting with a plan to meet in person in the spring.

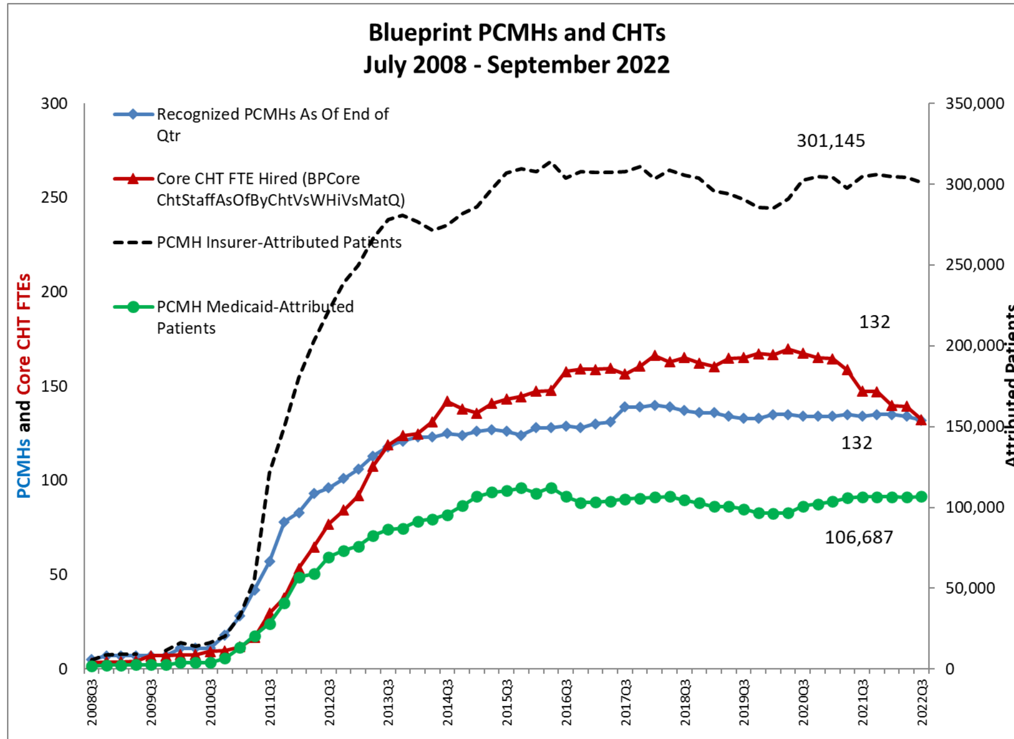
The visits included the Blueprint Program Manager, Quality Improvement Facilitator, Community Health Team leadership and staff, providers from Patient-Centered Medical Homes, and executive leadership at the Administrative Entity. In addition to the value of an in-person connection to all attendees, the staff's stories of helping Vermonters to overcome barriers related to transportation, food insecurity, new diagnoses, chronic disease, complex illness, emotional and mental health, poly-substance usage were inspiring. Repeatedly, teams emphasized the flexibility Community Health Team funding gives them to spend problem solving time with people in need without attention to insurance or ability to pay. Whether a short check-in via phone, a 20-minute conversation after a provider appointment to learn more about their adjustment and coping or a multi-hour coordinated effort by multiple team members and community partners that lasts months, Community Health Teams continuously delivered astonishing evidence of their positive impact.

C. Program Evolution

The Blueprint staff has had the privilege of responding to Sections 6 and 7 of Act 167 since Governor Scott signed S. 285 into law on June. In close coordination with the Secretary, Department of Health, Department of Mental Health, and the Department of Vermont Health Access and the Director of Health Care Reform, the Blueprint staff utilized the site visits as well as many other conversations and meetings to derive what was most important to address and how to address it. The result is a recommendation to increase the PMPM for Community Health Teams so that Health Service Area Administrative Entities can expand Community Health Workers, Mental Health Counselors and Social Workers to more fully address the mental health and substance use needs of the population and fund twenty Family Specialists who serve in a pediatric or family medicine primary care practice with the Developmental Understanding and Legal Collaboration for Everyone (DULCE).

III. PROGRAMMATIC UPDATES

1. PCMH



The Patient-Centered Medical Home (PCMH) is a model of care that has transformed how primary care is organized and delivered in Vermont. Delivering this model of care means:

- Clinician-led teams coordinate care, especially for disease prevention and chronic condition management
- Medical Homes coordinate with other care providers and community resources
- All members of the Medical Home team are committed to improving patient experience of care, health outcomes, and overall value of care

Vermont selected the National Committee for Quality Assurance's (NCQA) PCMH recognition model in 2008, which is now the most widely adopted PCMH evaluation program in the country.

In 2022, practices that were recognized Patient-Centered Medical Homes provided evidence and/or attestation that they:

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

Three (3) practices achieved a new transformation into a Patient-Centered Medical Home in 2022. Each of these existing practices changed organizational affiliation or had a substantial enough change in location, population served, or providers employed to require that they were required to undergo the full review process with NCQA.

One hundred twenty-nine (129) practices sustained recognition as a Patient-Centered Medical Home in 2022 by attesting that they meet the core requirements and providing additional evidence required for annual reporting. Typically, these practices began active preparation work six to nine months ahead of their anniversary date, working on ensuring that they understood any new standard requirements, were able to sufficiently able to provide the required evidence for standards that must be reported on an annual basis (e.g. medication reconciliation rates), and select and work on a minimum of six quality improvement projects across the domains of clinical quality measures, resource stewardship measures, appointment availability, and patient experience of care. Five of these practices were randomly selected for an in-depth NCQA audit in 2022.

This evolution of the recognition process has allowed for a greater focus on continuous quality improvement work in the practice while continuing to raise the quality standard of care in PCMHs. Practices are currently preparing to meet new standard requirements for 2023-2024 related to EHR utilization, standardized measure reporting, and enhanced focus on delivering culturally and linguistically appropriate services and reducing disparities in care.

In the context of a health reform environment working with both the PCMH and Accountable Care Organization (ACO) model, the Patient-Centered Primary Care Collaborative's 2018 publication[3] suggests that a strong foundation of primary care as embodied in the PCMH is critical to the success of care delivery reform. ACOs with a significant share of primary care providers that were an NCQA PCMH demonstrated better health promotion, prevention, and status scores, better chronic disease management, and higher overall savings.

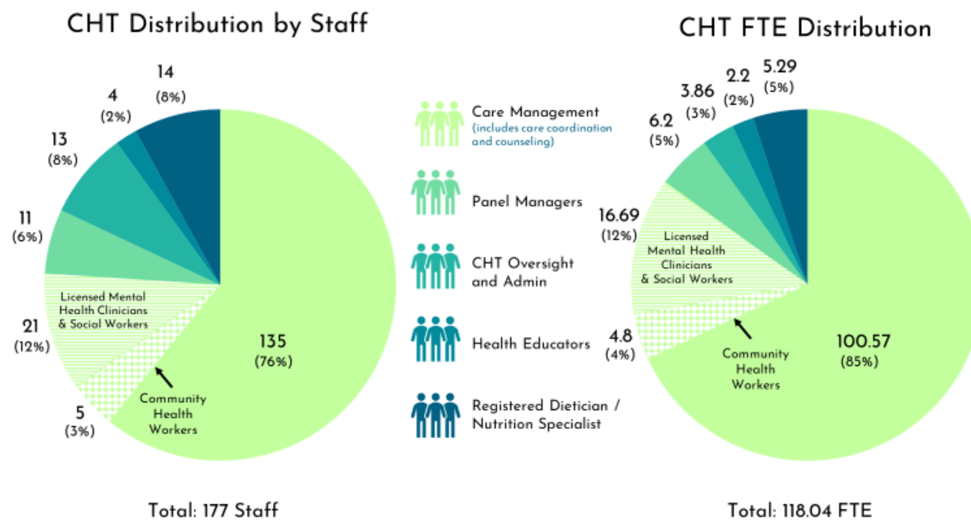
[3] Advanced Primary Care: A Key Contributor to Successful ACOs | Milbank Memorial Fund

QUALITY IMPROVEMENT FACILITATION

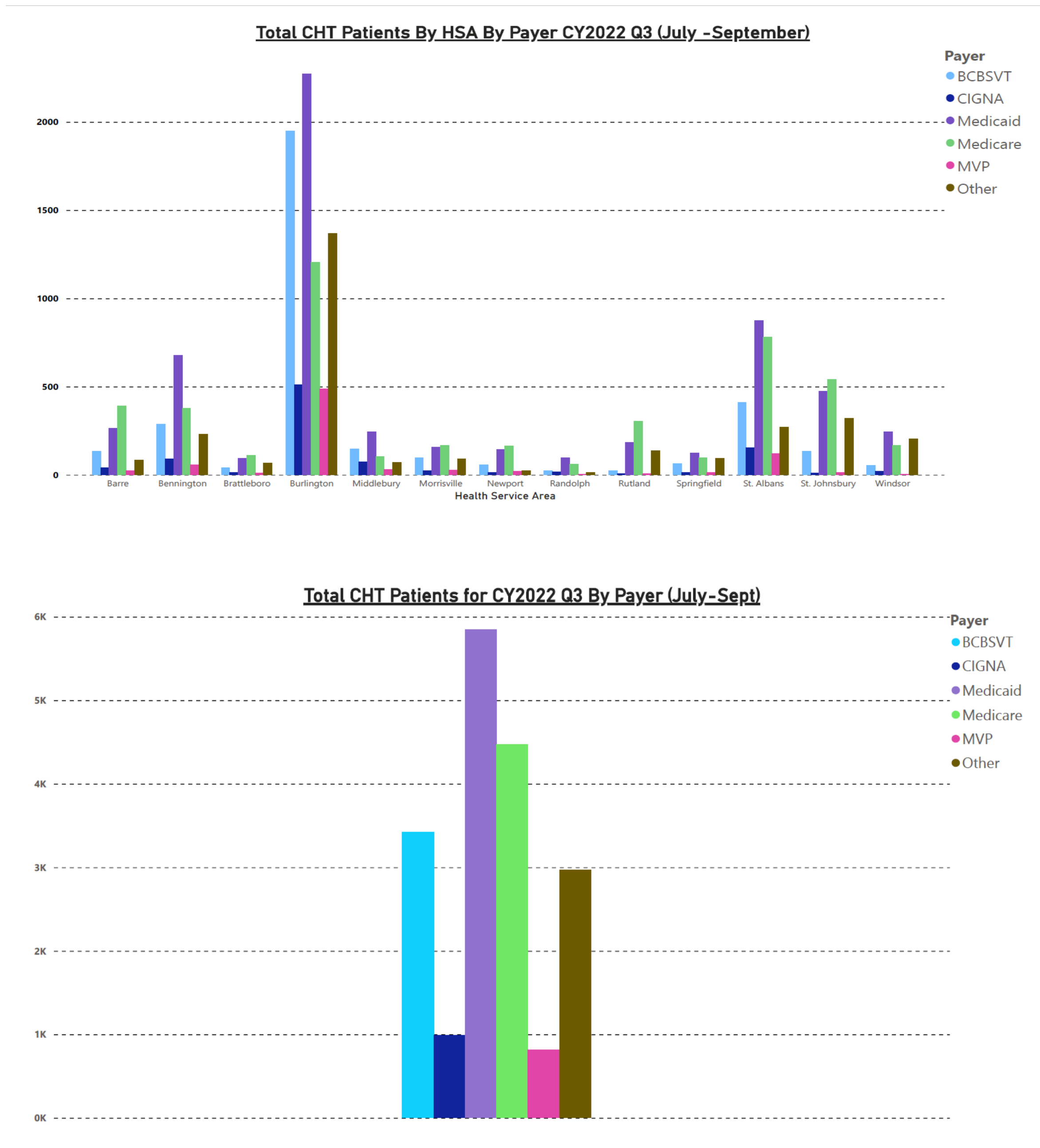
The Blueprint currently offers participating practices the services of a Quality Improvement (QI) Facilitator to support practices to improve the care they deliver, by focusing on implementation of evidence-based care or models of care to improve patient outcomes and experiences. Presently, there are eleven QI Facilitators shared amongst all participating practices. QI Facilitators are considered local experts in the Patient-Centered Medical Home Model and coach practices to achieve and retain National Committee or Quality Assurance (NCQA) recognition. The 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, and ongoing value-based care transformation in alignment with state-led health care reform priorities. 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).

2. Community Health Team Data

Along with the Patient-Centered Medical Home model, Community Health Teams are integral to the success of the Blueprint. These teams, funded by commercial and public payers, provide services to patients that are not generally covered by insurance. Services can include care coordination, social work, brief mental health interventions, referrals to services, and numerous other interventions, free of charge and without regard to insurance status. The types and distribution of CHT staff members in 2022 is highlighted below.



During 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.



3. Hub & Spoke

Hub & Spoke is Vermont's system of medication for opioid use disorder (MOUD) supporting people in recovery from opioid use disorder. The Blueprint administers the Spoke part of the Hub & Spoke system. For every 100 patients, the Blueprint supports communities to hire full time nurse and mental health clinician.

The Department of Health and the Blueprint for Health have been longstanding partners to support Vermont's hub and spoke providers, partners, champions and provider leaders together to share expertise and continue to improve the quality of care in the system. There is a language change that began this year and will be noted on ongoing communication and descriptions. Medication Assisted Treatment (MAT) is now referred to as Medication for Opioid Use Disorder (MOUD).

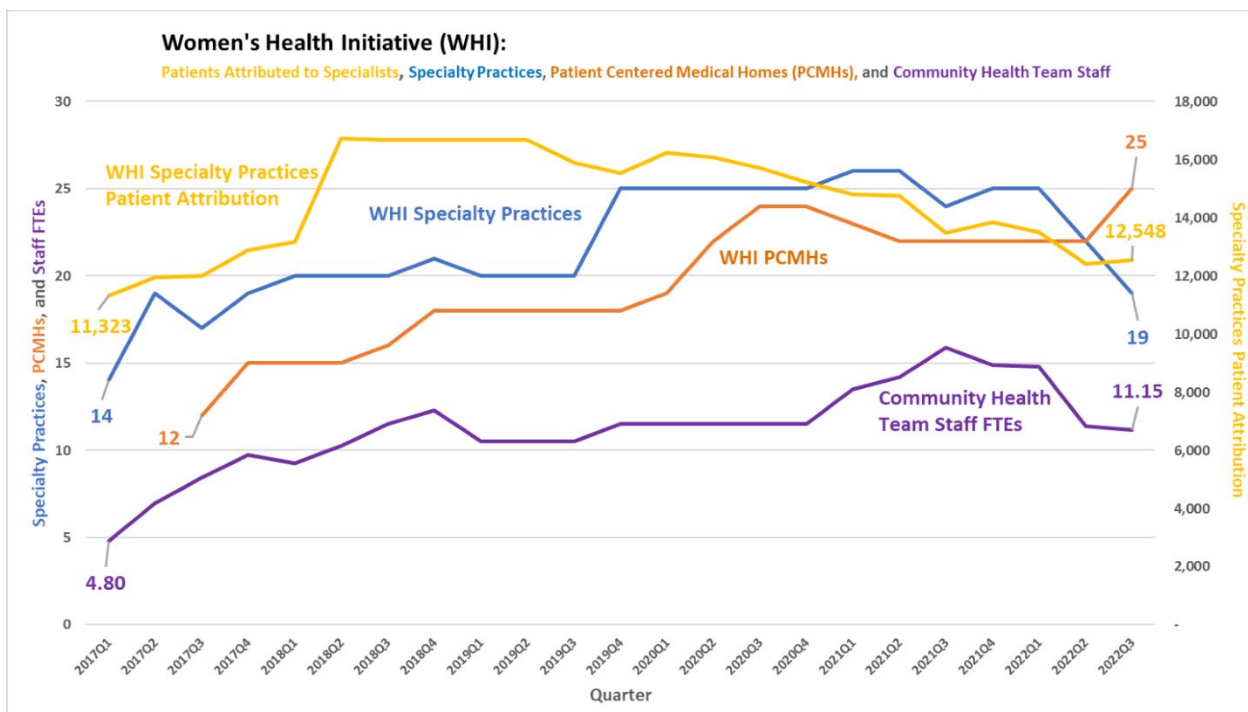
The Blueprint contract with Dartmouth College supports learning sessions with expert-led and peer-supported training in best practices for providing team-and evidence-based medication-assisted treatment for opioid use disorder. Five webinars, three virtual workshops, and a virtual conference were held from January through October of 2022. Sessions alternated between didactic care management webinars and multidisciplinary care management workshops.

Vermont continues to demonstrate substantial access to medication-assisted treatment by funding registered nurses and licensed, Master's-prepared, mental health/substance use disorder clinicians as a team. These teams offer evidence-based treatment and provide Health Home services for Vermonters with opioid use disorder.
Throughout the pandemic, Vermont's Hub and Spoke providers were able to maintain access to life-saving treatment at all times. At no point did Hub and Spoke providers have to shut their doors to Vermonters in need of care. The Blueprint continues to encourage the use of VT Help link is a free and confidential referral service available to connect people to resources and treatment (802-565-LINK or VTHelplink.org)

4. WHI

The Women's Health Initiative (WHI) strives to support people who can become pregnant in their efforts to experience healthy pregnancies, avoid unintended pregnancies, and build thriving families. The WHI provides increased mental health and social service staffing at specialty practices and utilizes the existing CHT at Blueprint PCMH practices. If a patient identifies as at-risk, they have access to a mental health clinician for brief interventions, counseling, and navigation to community-based services and treatment as needed. The Blueprint has continued to outreach to practices to share the mission of the WHI program and assess interest in incorporating the program into their practice. The past year was significant for the WHI program in that Planned Parenthood of Northern New England (PPNNE) closed four offices. The Blueprint worked closely with communities where locations closed to assess the impact of the closure and the needs of the community.

The Blueprint reinstated in-person trainings to support the WHI network of providers in contraceptive care. In collaboration with University of Vermont, Dr. Lauren MacAfee has trained over 50 providers from Blueprint WHI sites in long-acting reversible contraception insertion (LARC) and best practices around patient choice of contraception in the past year. The community providers requested further training and support for individuals who want to increase comfortability and knowledge in gender affirming care. The Area Health Education Centers and University of Vermont Project Echo agreed to support the WHI network and will provide monthly training for 6 months for providers to increase knowledge and comfortability in gender affirming care beginning in January 2023.



Health Service Area	WHI Specialist Practices as of September 2022	WHI PCMH Practices as of September 2022	WHI CHT Staff FTE Hired as of September 2022	WHI Specialist Quarterly Attributed* Medicaid Beneficiaries as of September 2022	WHI PCMH Quarterly Attributed* Medicaid Beneficiaries as of September 2022
Barre	1	1	0.75	530	374
Bennington	1	2	0.6	833	253
Brattleboro	1	0	0.6	900	0
Burlington	2	9	2	1886	4809
Middlebury	1	0	0.75	622	0
Morrisville	1	3	0.5	297	1228
Newport	1	0	1	917	0
Randolph	2	0	0.5	269	0
Rutland**	2	0	1.5	1883	0
Springfield	0	5	0	0	1697
St. Albans	0	0	0	0	0
St. Johnsbury	1	2	0.75	817	691
Windsor	0	3	0	0	87
Planned Parenthood (Statewide)	6	0	2.2	3381	0
Total	18	25	11.15	12335	9139

5. Self-Management Programming

Over time, the Blueprint team has evaluated the efficacy and efficiency of the Self-Management Programming offered through the Blueprint grants to Administrative Entities. Beginning in 2019, the Blueprint began conversations with partner organizations, both within and outside of state government, to determine the best future for programming that engages patients in improving health and managing chronic conditions. After several years of analysis and discussions, the Blueprint and the Vermont Department of Health entered into a Memorandum of Understanding (MOU) to work more closely together for the provision of Self-Management Programming. While the Blueprint still provides the funding and oversight, the Health Promotion and Disease Prevention (HPDP) unit within the Department of Health administers the programs through grants to local hospitals and Federally Qualified Health Centers (FQHCs). This partnership takes advantage of the additional funding and content expertise that exists within HPDP, and pairs it with the Blueprint's influence at the local level.

Health Service Areas offered six types of Self-Management Programs during 2022:

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

From October 2021 through September 2022, the Department of Health and the Blueprint saw an increase in participation in Self-Management Programming overall. There were 122 workshops offered, with a total of 538 individuals completing a program. This is a 14% increase from the previous grant year, during which 471 individuals completed a program. The Diabetes Prevention Program and the Blood Pressure Management Program had the largest numbers of workshop completers.

IV. EVALUATION

A. Healthcare Measurement Results for Blueprint Target Populations

1. Healthcare Claims and Clinical Data

Since its inception, a core mission and statutory responsibility of the Blueprint has been to support service delivery reform and evaluate quality and cost outcomes through analysis of multi-payer claims and clinical data. For analysis of multi-payer populations (given the Blueprint's statutory multi-payer responsibilities), the Blueprint partnered with the Green Mountain Care Board (GMCB) to add Blueprint evaluation work to the GMCB's existing all-payer analytics contract. Calendar Year (CY) 2020 is the latest year for which we have multi-payer, population-level, healthcare measurement data for Vermont, and it represents the time period with the greatest disruptions and lockdowns of the COVID-19 pandemic. The following annual healthcare evaluation measures were calculated by Onpoint Health Data, under contract with the GMCB and Blueprint program. Claims-based measurement results are derived from the Vermont Health Care Uniform Reporting and Evaluation System (VHCURES), Vermont's all-payer claims dataset (APCD) managed by the GMCB, clinical/hybrid measures for CY 2019 used records from the Blueprint's recently discontinued Vermont Clinical Registry (VCR), and clinical/hybrid measures for CY 2020 used clinical data from Vermont Information Technology Leaders (VITL). Blueprint practice and provider registry information used for primary-care patient attribution was derived from the Blueprint's own web portal database. Further details related to the Blueprint CY 2020 community health profile measures are posted on the Blueprint for Health website at:

https://blueprintforhealth.vermont.gov/community-health-profiles.

Populations of Analysis.

In CY 2020, 68.8% of VHCURES members who received primary care services were served by Blueprint Patient-Centered Medical Homes (PCMHs). Because of this large degree of overlap, measurement results for the total VHCURES population and for the PCMH-attributed population are generally similar and, consistent with our annual reports of prior years, we present here measurement results for the wider primary-care service target population of VHCURES members (i.e., individuals enrolled as in a health plan reporting to VHCURES), minus a small number of exceptions. This represents a multi-payer member sample, independent of primary-care attribution and independent of Accountable Care Organization (ACO) attribution. In 2020, this VHCURES data represented 430,060 people, or 66.9% of Vermont's 2020 population.

As in prior Blueprint annual reports, this report attempts to address the significant shift in

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

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

COVID-19 Impacts.

Due to the CY 2020 COVID-19 pandemic lockdowns' effects on healthcare utilization, Blueprint patient-attribution and healthcare measurement data for CY 2020 is unprecedented and not comparable to data for other years. Blueprint population-health evaluation measure results for calendar year (CY) 2020, as compared to CY 2019, show widespread and, in some cases, dramatic decreases in healthcare expenditures, utilization, monitoring, preventative services, and/or desirable outcomes. These shifts in measurement results coincide with a time period in which patients were reluctant or unable to access in-person care, and in which the healthcare system in Vermont was overwhelmed, struggling to maintain adequate staffing, and struggling to make a rapid transition to telemedicine and other remote services.

2. Population Counts and Demographics

Statewide Demographics	CY 2020	CY 2020
U.S. Census Population Estimate for Vermont for 2020: 643,077.	Total VHCURES (Excluding Self-Insured) Members	Blueprint PCMH Primary Care Attributed Members
Population N	430,060	262,641
N Adults 18+		75.5%
N Pediatric 1-17		24.5%
Avg. Age	43.1	43.1
% Female	53.0%	54.0%
% Medicaid	31.0%	30.0%
% Medicare	28.0%	30.0%
% Commercial	41.0%	40.0%
% ACG Healthy Users	9.0%	9.0%
% ACG Low Risk	14.0%	16.0%
% ACG Medium Risk	42.0%	45.0%
% ACG High Risk	15.0%	16.0%
% ACG Very High Risk	8.0%	8.0%

Evaluation measure results are presented in the appendix of this report. In those results, regional breakouts are based on Vermont Department of Health HSA4 Hospital Service Areas (HSAs). A map of these HSAs can be found on the Vermont Department of health's website at:

http://www.healthvermont.gov/GIS/.

B. Expenditures and savings for the period

1. Blueprint Expenditures

Blueprint for Health Annual Budget by Program Elements and Funding Source

Blueprint Program Elements	Annualized Budget for 2022	Description	Money Flow	Payer Participation
Patient-Centered Medical Home (PCMH) Payments	$12,618,853	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)	$10,054,402	Teams support PCMH practice and interface with community services	From Payers to Local Hospital (or FQHC)	All Payers (Includes Medicare)
Spoke Staff (Extended CHT)*	$7,262,684	RN & Counselor teams support MAT prescribers	From Payer to Local Hospital (or FQHC)	DVHA / Medicaid
WHI PMPM Payment to Specialty Practices	$182,638^	Attestation to program elements	From Payer to Practices	DVHA / Medicaid
WHI PMPM Payment to PCMH Practices	$93,670^	Attestation to program elements	From Payer to Practices	DVHA / Medicaid
WHI One-Time Practice Payments	$0	Workflow changes for screening, same-day long-acting reversable contraception	From Payer to Practices	DVHA / Medicaid
WHI Social Workers (Extended CHT)	$1,001,427	Staff for brief interventions and navigation to services	From Payer to Local Hospitals (or FQHC)	DVHA / Medicaid
WHI Program Management	$28,000	Program Administration and staff supervision	Grant to PPNNE	DVHA/ Medicaid
Program Management	$1,427,000	Change management & program administration	Grant to Local Hospital (or FQHC)	DVHA / Medicaid
Quality Improvement Facilitators	$1,140,544	In practice QI coaching for NCQA, ACO priorities, and practice priorities	Grant to Local Hospital (or FQHC) or Contract w/ QI facilitator	DVHA / Medicaid
Community Self-Management Programs	$664,163	MOU with Department of Health to support local Self-Management Programs	VDH grants to Local Hospital (or FQHC)	DVHA / Medicaid
Training Contracts/Grant(s)	$700,900	WHI UVM Faculty Trainings	Contracts with Vendors	DVHA/Medicaid

		Dartmouth Spoke Provider Trainings WHI PPNNE Contraceptive Counseling Trainings		
Health IT Grant **for staffing to manage Support and Services at Home (SASH) care management system**	$205,000	Grant to administrative entity for the Vermont SASH program, for staffing.	Grant to Senior Housing Organization	DVHA/Medicaid
Data and Analytics Contracts				
All-Payer and Medicaid Analytics	$604,600	Program evaluation for performance payments and for State and Federal reporting.	Contract with Vendor	DVHA / Medicaid
Patient Experience of Care Survey	$226,840	Survey of Vermonters served in primary care in accordance with statute	Contract with Vendor	DVHA / Medicaid
Blueprint **Central Office Staff**	$1,023,689	Central office Blueprint program staff.	State Employees and Contracted Staff	DVHA/Medicaid

* Vermont Department of Health manages Hubs
^Fourth quarter data is not yet available for WHI PMPM payments, so the dollar amount is an estimated number based on previous quarters.

C. Results of patient and provider satisfaction surveys (CAHPS) (Jenn)

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

A full report including the survey questions for each composite above and results from the 2021 patient experience survey is available at:

Patient Experience: 2021 Consumer Assessment of Healthcare Providers Survey (CAHPS) Results (vermont.gov)

V. HEALTH SERVICE AREAS

The Blueprint staff in each Health Service Area are responsible for the continued success of the program and have worked during 2022 to move beyond pandemic response to address the ongoing needs of their communities. The following section of the report includes in-depth information provided by each HSA.:

Barre Health Service Area

Program Manager: Michelle Gilmour

47,413	Heath Service Area Total Population
29,048	Blueprint Practices Patient Attribution
9.74	Community Health Team Staff Full Time Equivalents (FTEs)
5.05	Spoke staff FTEs
.75	Women's Health Initiative Staff FTEs
3,295	Community Health Team Patient Count (January - September 2022)
186	Spoke-Eligible Patient Population (Average August -October 2022, Medicaid only)

Community Health Team

In the Barre HSA we embrace the definition of community health teams as locally based, multi-disciplinary teams that manage patients' complex illnesses across providers, settings, and systems of care. Our CHT combines funding from multiple sources (Blueprint, OneCare and locally funded) and has 32 members spanning the roles of Care Management/Social Worker, Dieticians/Health Coaches, Behavioral Health Clinicians, Tobacco Cessation Counseling, Panel Managers, MAT RNs and Care Coordinators. We have a hybrid approach with most staff embedded in the clinics most days and our panel managers centralized outside of the clinic. We continue to leverage telemedicine to provide services to patients across clinics and to coordinate care with and among our community partners.

Our team of social workers and care managers remain part of our CHT and are now also part of the UVMHN Population Health Service Organization (PHSO). Through this collaboration we now leverage standardized documentation templates, making it much easier to capture care team membership and goals of care. Additionally, this team has been advancing our efforts to improve screening for social determinants of health, allowing us to more accurately risk stratify our patients and engage with those at highest risk.

Our WHI participating clinics have implemented screening for social determinants of health, including the One Key Question, and are actively working to streamline the process further. Working with Central Vermont Home Health and Hospice, our Women's clinic has created a clinical pathway for perinatal care involving referrals to integrated behavioral health, CHT registered dietician and home health to support healthy pregnancies and families.

> "The CHT is a collaborative partner we have in the practices to support our patients. Because of the CHT we're able to start a patient on a new medication or referral for services while inpatient and can do a warm hand-off back to the clinic and know there's someone there to follow through and ensure any barriers to receiving the medication or care as an outpatient are addressed. It provides for continuity of care."
>
> – Inpatient Case Management

Barre Health Service Area
Continued

Achievements & Accomplishments

THRIVE, our community collaborative, was leveraged to complete our CHNA this year. We used our members to establish a CAN (community action network) that met during the process to guide and provide feedback. We also asked THRIVE members to cascade the survey tool throughout their team and client base. As a result we had a high level of participation. We also used their insights to identify BIPOC and LGBTQ+ community members. We have leveraged THRIVE for our Health Equity grant and also for the Working Communities Challenge grant.

We re-established the Central VT Opioid Council (RAM/Hub/Spoke meeting) in effort to improve coordination and collaboration amongst substance use treatment providers, access to care, and data collection efforts to better understand census and flow between levels of care in our region. Through this collaboration we maintained access to buprenorphine for patients when faced with regional hub inability to accept new referrals. We have enhanced distribution of harm reduction kits within our primary care sites, providing education to clinic staff and promoting efforts regionally.

> I have been practicing medicine for 20 years now and I know what medicine was like before a CHT. I can say with some confidence that our community health team is the only reason that I am still in practice. Without a team approach to help manage complicated patients with multiple medical and social needs many of my patients would fall through the cracks. The demoralizing nature of not being able to help would likely force me to find another career. With the CHT I feel like we can always help no matter how big the problems are!
>
> – Family Medicine Physician

Members of our CHT behavioral health team received CALM training and are presently participating in CAMS training. Additionally. they support our local Refocus on Alcohol dependence (ROAD) pilot, aiming to create pathways and expand access to MAT and services for our patients with alcohol use disorder. Our MAT team is actively working to standardize workflows and documentation to capture all care team members and improve coordination across the system of care.

> Patients benefit because we have the ability to do what is needed to support the person in achieving their optimal level of well-being and have a team to reach out to for needs that we cannot fulfil.
>
> – CHT member

Future Goals

In the coming year we will continue to focus on improved communication, collaboration and transitions of care. We have workgroups focusing on our high ED utilizers and readmitted patients to identify themes and opportunities to address some of the root causes within our system of care, while not duplicating efforts. For example, our CHT member embedded at The Health Center was able to identify transportation as a theme and driver of high ED utilization for their patients. We are now scoping a project with our QI facilitator aiming to further define and make recommendations to address this need.

Our teams across the community are working to end suicide. Central Vermont Medical Center was a sponsor of the Out of the Darkness suicide prevention walk held in Montpelier in October with representation from our CHT, Washington County Mental Health Services and many other organizations. We will be working to optimize our suicide screening and referral protocols in the coming months.

Bennington Health Service Area

Program Manager: Caitlin Tilley

27,483	Heath Service Area Total Population
19,584	Blueprint Practices Patient Attribution
9.95	Community Health Team Staff Full Time Equivalents (FTEs)
5.45	Spoke staff FTEs
0.8	Women's Health Initiative Staff FTEs
4,352	Community Health Team Patient Count (January - September 2022)
419	Spoke-Eligible Patient Population (Average August -October 2022, Medicaid only)

Community Health Team

The landscape of the Bennington HSA has changed dramatically over the last year with the closure of a large independent practice, the loss of our local Planned Parenthood office and staffing transitions in Spoke practices. The Bennington CHT serves 14 practice locations across the HSA These 12 practices include 1 FQHC, 5 hospital owned practices and 6 independent practices. The Bennington Blueprint for Health supports four PCMH sites that provide embedded MAT services within their practices and two PCMH sites that participate in WHI. Additionally, there are two specialty practices that participate in WHI or Spoke programs.

Overall, the CHT is embedded within the practice setting; we actively partner with our designated mental health agency, United Counseling Services, to provide embedded behavioral health resources in these practices as well. Registered Dietician and Social Work supports in the Bennington HSA are more centralized with one person receiving referrals across the entire HSA. The CHT team members collaborate across agencies and disciplines to ensure effective care coordination of routine and complex care, specifically around care transitions.

> The collaboration between Spoke nurses, community partners and patients is one that always have very meaningful outcomes when everything falls into place. This type of coordination is not extraordinary, but rather the normal for these teams. An example of the impact this work has on individuals and the community can be demonstrated when you see the response to an overdose in Bennington in the following example:
>
> A patient overdosed while with some acquaintances. They report that everyone at the scene "just left them there" and they easily could have died. Fortunately, one of the individuals did call 911 before leaving. Emergency services arrived, and after three doses of Narcan, the overdose was reversed. Fortunately, a Peer Recovery Coach from Turning Point was at the scene and was able to encourage this person to get follow-up care. After stabilizing in the ED, they were given a dose of Suboxone and agreed to follow-up with a local Spoke office to begin treatment. They shared that while in the ED, theyactually had no intention to follow-up with the Spoke, and only agreed so they would be discharged. It was not until a Spoke RN contacted them the following day that they actually considered continuing MAT and entering treatment. They stated that the Spoke RN was extremely helpful and supportive, and made it very easy to attend their first appointment. In addition, they greatly appreciate the counseling services they received in the Spoke office. They stated that they were reluctant to begin counseling, but now find it extraordinarily helpful and considers it an invaluable part of their recovery. They reports that the continued support of Spoke services is a large part of why they have succeeded in treatment, and feels confident they can continue knowing they have people and a program they can rely upon.
>
> - Spoke Team Member

Achievements & Accomplishments

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

The Bennington Spoke Program was able to successfully navigate patient transitions due to a participating practice closure without interrupting treatment plans for the MAT patient served through strong collaboration between practice leadership and Spoke RN case managers. Throughout 2022 the HSA met initiation and engagement benchmarks for all patients requesting access to MAT; these patients were all able have a coordinated intake appointment within 72 hours of presentation and much of this success can be attributed to the Spoke RNs who play a vital role in outreach and treatment coordination. Additionally, our local emergency department team is a strong advocate of rapid access to medication (RAM) assisted treatment, and facilitate peer recovery connections via Turning Point and the Spoke team.

Efforts led by the Bennington Spoke team have resulted in numerous harm reduction efforts being implemented across the HSA; in partnership with community agencies, we have been able to increase community access to Narcan and Overdose First Aid to decrease the instances of overdose fatalities.

Our WHI social worker has continued to support participating practices through referrals identified through practice screening processes. A significant focus of these referrals focuses on pregnancy intention as well as Social determinants of Health(SDOH)related needs that persist beyond the initial years of the pandemic. Conversations with WHI providers regarding gender inclusive care needs in the community after the closure of Planned Parenthood of Northern New England (PPNNE) have highlighted a significant interest in making both big and small improvements in access to inclusive care within the community.

Key areas of QI focus for the past year have included relationship development and engagement with each practice specifically around the expected reporting standard changes for CY23 to ensure continued PCMH status. This has included work in policy review and revision, EMR system alignment with NCQA expectations and ongoing QI support. We have extended QI consultation to our MAT and WHI specialty practices should needs be identified to support ongoing QI facilitation across the entire Blueprint care continuum. We hope to be able to continue to support the larger QI team in evaluating workflows and toolkits that can increase access to care across all HSAs.

Future Goals

Monthly Care Coordination and Collaborative meetings have been an invaluable avenue to ensure that our Blueprint team and key community stakeholders remain connected and working towards achieving goals around shared care planning, improved collaboration and communication and eliminating duplication of services where possible. Work has been done to ensure that the right people are at the table for these meetings to facilitate valuable use of time across agencies. Through these meetings we have been able to facilitate meaningful connections between organizations and communicate updates that impact all aspects of care coordination. We continue to utilize these meetings as opportunities to support successful participation and engagement of ACO participants with the ACO network, often reserving a standing agenda item for ACO updates, education and data feedback.

With the loss of a large primary care practice in the service area, access to primary care is a top priority for this community due to the barriers it creates in care coordination. The work that has been done to build relationships across the care continuum and the community will continue to support meeting patient needs in innovative ways while primary care access stabilizes. The Blueprint team is often the first point of contact when challenging situations without a clear answer arise. With limited access to primary and specialty care providers, our Bennington leadership team is working to create opportunities for early identification of increased ED and inpatient utilization to support chronic disease management, meet social needs for individuals, eliminate barriers to care when possible while bridging to long term solution development across the community.

…I also work closely with specialty educators, such as Diabetes Educators. On one such occasion a patient had been in the hospital for Congested Heart Failure and diabetes and was referred to the diabetic educator after discharge. At his visit he talked about losing his job due to his health decline and lack of resources for food. He had been working part time at a local restaurant and depended the food given to him at the restaurant. Due to his health decline, he was unable to pick up shifts and was not eating as well as normal. He admitted a poor diet was a leading cause to his CHF and poorly controlled diabetes.

He was referred to me for community resources. I was able to give him a list of food resources, connected him with Economic Services to get disability and Social Security assistance, and referred him to Support and Services at Home (SASH). SASH was able to sign him up for a food drop program that delivers fruits and vegetables. He also joined a walking program.

Another time I met with him he told me that his sister was dying from cancer and he was unable to make the trip to Canada to see her because he did not have money for gas to make the trip and return home. I called the local Interfaith Council and explain his situation. They were able to provide him gas cards with enough gas money for him to make the trip and return home. He met with me a few months later to thank me for helping him. He shared that he was able to visit his sister and spend time with her before she passed. He was grateful for that last gift.

These are just two situations that describe the type of the care coordination that I provide to patients. I enjoy working with my patients and being able to provide the resources that support them.

\- CHT RN Case Manager

As a telephone triage registered nurse in the primary care medical practice setting, it is immensely helpful to have embedded Community Health Team (CHT) members to assist with care coordination We speak to 100's of patients per day with a wide array of clinical questions, medical symptoms, and social determinant of health barriers and needs including transportation, financial strains, family dynamics, and health literacy issues to name a few. We often field various questions from recently discharged patients seen in emergency department, inpatient, and or skilled facility settings. Once we have determined their needs/presentation does not warrant immediate medical intervention or dispositioning back to an emergency department for evaluation their other clinical care and social needs surface. Being able to confidently hand off medically and socially complex primary care patients to embedded registered nurse case managers not only positively impacts the outcomes of the patients clinical or social situation, it cultivates a personal connection with their care team, and further solidifies the impact that primary care engagement has on the overall wellbeing of patients, families, and the community. We could not do what we do without the CHT RN case managers, they are a core to primary care and are ultimate patient advocates. The RN case managers effectively and nimbly navigate a multitude of complex and often times over-taxed resources to ensure the patients are service connected, listened to, respected, and have the autonomy to truly lead their own person-centered care.

\- Primary Care Telephone Triage RN

Brattleboro Health Service Area

Program Manager: Rebecca Burns

22,634	Heath Service Area Total Population
12,695	Blueprint Practices Patient Attribution
6.3	Community Health Team Staff Full Time Equivalents (FTEs)
4.3	Spoke staff FTEs
0.6	Women's Health Initiative Staff FTEs
2,406	Community Health Team Patient Count (January-September 2022)
192	Spoke-Eligible Patient Population (Average August -October 2022, Medicaid only)

Community Health Team

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

> "My patients would never be able to have access to a dietician if it wasn't for Community Health Team."
>
> – Primary Care Provider

Achievements & Accomplishments

The CHT has also been involved with a Primary Care transformation project. Team based care is a focus in providing high quality care to our community. As always, being able to provide individual care to patients, that is not based on a fee for service model is our biggest accomplishment. Watching and participating with patients in their wellness journey is a such a privilege.

The Accountable Communities for Health (ACH) has continued with a focus on addressing Mental Health resources in our community. The group was able to create a workgroup that is digging into finding ways to increase services to our area. This workgroup is the next step in this work and couldn't be done without all the partners at the table. Our CHT lead facilitates a monthly care coordination meeting to discuss needs and resources in our community. Participation has increased when moved to a virtual platform. Healthworks, a collaboration between Brattleboro Memorial Hospital, Brattleboro Retreat, HCRS and Groundworks continues to embed clinical staff into the shelter to assist folks who are unhoused in our community with healthcare, including mental health care. The program has received multi year funding and will be tracking data around this work.

Key QI Work

All current PCMH practices regained PCMH recognition! This is possible due to the amazing assistance our QI Facilitator provides to each practice. Improving access and quality are major focusses in this work. QI work continues with the Women's Health Initiative (WHI). Our QI facilitator is integrated in our monthly meetings and provides continuous framework and information to improve care through SBINS screening and increase access to LARC. Our QI facilitator is also providing guidance around the Primary Care transformation process. This work is invaluable and she bring such expertise to the process.

> Being able to provide time unlimited services, flexibility and care iswhy I went into this work in the first place. Being able to take the time to assist patients withwhat theyactually need feels amazing!
>
> – CHT staff

> I love being able to hear all the work the CHT staff do with patients. Theyare able to advocate, support and be creativein meeting the patients needs. This work is truly invaluable to the community.
> I can't say it enough!
>
> - Program Manager

Future Goals

We continue to hold care coordination meetings monthly internally and with community partners. Communication is key to decrease duplication. Relationship building and shared understanding of what each organization provides is crucial to this process.

We will continue to work with the practices around chronic disease management through our care coordinators, health coach and registered dieticians. We will also be exploring other grant opportunities to support the work around chronic disease management and prevention. CHT continues to advocate for and assist with screenings around substance use disorder and suicide risk. Care coordination around access to primary care and specialty care is a major function of the CHT.

Burlington Health Service Area

Program Manager: Kerry Sullivan

116,675	Heath Service Area Total Population
90,898	Blueprint Practices Patient Attribution
32.85	Community Health Team Staff Full Time Equivalents (FTEs)
23.29	Spoke staff FTEs
2	Women's Health Initiative Staff FTEs
19,647	Community Health Team Patient Count (January - September 2022)
1,092	Spoke-Eligible Patient Population (Average August - October 2022, Medicaid only)

Community Health Team

The Burlington Health Service Area's Community Health Team is deployed across 25 practices in 37 unique locations to meet the varied and individual needs of our community's participating primary care practices. There are three categories into which our HSA breaks down: (1) our FQHC - Community Health Centers; (2) our independently owned primary care practices; and (3) our network of hospital-owned primary care practices.

Many of our CHT members (48%) are hired through our Blueprint Administrative entity and deployed within practices to provide wrap-around services that help our patients address barriers to care and access additional resources to meet their health goals successfully. Other CHT members (52%) are hired directly by a practice that opts to receive pass-through funding so they can embed and deploy staff in a way that best suits their practice needs.

In the Burlington HSA, there are 32 FTEs employed with CHT funding. CHT roles currently include care coordinator, social worker, panel manager, acupuncturist, administrative support, health educator, psychologist, psychiatrist, and registered dietitian. The Burlington Health Service Area includes 11 practices participating in the WHI program and 2 dedicated WHI social workers. 21 practices provide MAT/Spoke services, with 23 RNs and Licensed Drug and Alcohol dedicated to the program.

There are many opportunities within our HSA for formal care coordination amongst teams, which include: monthly countywide Spoke meetings, MAT triage team meetings, community Local interagency team meetings, Choices for Care meetings, and our Care Coordination Leadership Meetings. Most care coordination happens through our staffs' knowledge of community resources and the work of the CHT/MAT/WHI in our greater community, which allows for constant outreach and connection.

Achievements & Accomplishments

Medication Assisted Treatment (MAT) patients find positive outcomes: The people in our MAT programs in primary care offices have experienced tremendous growth this year. Our patients have found meaningful employment, returned to school/college, repaired family relationships, reunified with children, gotten their driver's licenses back, bought cars and homes, and created futures for themselves and their families. These positive outcomes can be attributed to the complex work individuals put into changing their lives and our person-centered approach, which helps to foster these changes. UVMMC Care Management enhances documentation efforts: The UVMMC Care Management Team ensures the program meets the highest standards of evidence-based patient-centered care. Examples of this work include consistency in how and when assessments are completed, plans of care, and a consistent way to identify the Care Manager as part of a patient's healthcare team in Epic. My Healthy Vermont (MHVT) Self-Management program connects to Vermonters: Despite scheduling and technical capability challenges, we have successfully connected Vermonters to our self-management programs.

As a result of going to 100% virtual delivery of programming during the pandemic, we reached Vermonters who previously could not dream of attending an MHVT program. However, we also learned that many Vermonters were unable to join a virtual program due to a lack of access to technology or a lack of technical capabilities, for example. To address this, we partnered with SASH to successfully offer a Diabetes Prevention Program and a Blood Pressure Management Program in a hybrid format; participants met in person in SASH's common space along with a SASH coordinator who operated the computer and Zoom meeting. Suicide Prevention Support for PC Construction Crew Members: Chittenden Accountable Communities for Health (CACH) has established a partnership with the Center for Health and Learning (CHL) to provide suicide prevention support to people in the construction industry (construction is the second highest industry in terms of risk of suicide). The first UMatter training will be provided to 80+ PC Construction crew members in January 2023.

I feel honored to be on a team of professionals who support individuals in their recovery from substance use disorders. When people are stable, they greatly benefit from receiving MAT in their primary care homes by providers who know them best and can address their medical needs and offer preventive healthcare services. When an individual resumes substance use, I know I have the support of the medical center's Addiction Treatment Program, which provides comprehensive treatment, like medication initiations, psychotherapy, psychiatric assessments, and consultation. Together with community agencies and social services, I feel confident in helping my patients access the resources and supports they need to improve their lives.

- LADC, LICSW Mental Health Clinician, UVMMC MAT program

Future Goals

Burlington HSA Blueprint Team will develop a solid understanding of the new OneCare Vermont Population Health Model (PHM) in order to support practices as they integrate this model into the Patient Center Medical Home (PCMH).Minimizing duplication of services. In July 2022, the UVMMC care management team developed and operationalized the use of standardized templates, consistent with best practices as outlined by NCQA standards for Care Management accreditation, to capture patient assessment and care plans in Epic. By October 2022, 72% of care-managed patients in the network had the completed template in their chart. The goal is to reach 95% in 2023. The UVMMC Care Management Program is seeking NCQA Accreditation as a care management program in 2023. QI facilitators will promote chronic disease self-management programs. Practices will continue to focus on the management of high blood pressure and diabetes. Practices involved with the Vermont Department of Health's Chronic Disease Prevention Initiative grant have been working on implementing continuous glucose monitoring (CGM) and a blood pressure cuff "lending library" for their patients with Diabetes and Hypertension.

Reducing deaths by overdose/suicide CACH has produced meaningful outcomes while continuing to work with community partners, PCMHs, and the Blueprint Team. The entirety of CACH's work has focused on supporting the APM goal of reducing deaths by suicide in our community. CACH will continue to conduct training for primary care practices on how to utilize best-practice evidence-based suicide screenings and interventions. Our Spoke Partners will continue to participate in the Burlington Mayor's Office Community Statistics meeting which addresses trends in overdose deaths and identifies strategies to improve access and outcomes for patients living with addiction. Accessing primary care and specialty care Integrating clinical social workers into OB/GYN sites through the Women's Health Initiative helps patients access mental health and social work services more readily (as well as more comfortably). WHI support is often an "on-ramp" or springboard to other services that may be needed. WHI social workers provide care coordination, short-term counseling, and considerable follow-up.

> The Blueprint helps support essential patient-centered care in our community. We as social work care managers are able to be nimble, creative problem solvers to support patients and families in their time of need. Those needs vary on a wide spectrum from financial and housing needs through to social-emotional health needs. I'm thankful to be a part of the patient journey; medical homes are essential for whole health care.
>
> \- Social Work Care Manager

Middlebury Health Service Area

Program Manager: Sylvie Choiniere

19,398	Heath Service Area Total Population
17,805	Blueprint Practices Patient Attribution
3.5	Community Health Team Staff Full Time Equivalents (FTEs)
2.25	Spoke staff FTEs
0.75	Women's Health Initiative Staff FTEs
1,975	Community Health Team Patient Count (January-September 2022)
205	Spoke-Eligible Patient Population (Average August -October 2022, Medicaid only)

Community Health Team

The Community Health Team staff is embedded in the various Patient-Centered Medical Homes, Spoke Sites, and Women's Health Office. There are staff that are hired directly by the Administrative Entity and deployed to the offices, and there are staff that are hired directly by the offices and funding is passed through to support their CHT role in the office. The overall team includes various professions such as Case Managers, Care Coordinators, Panel Managers, Behavioral Health Clinicians and Dietitians. These roles all function to provide wrap around supports that focus on the social determinants of health and promote wellbeing.

Achievements & Accomplishments

With the help of RN Case Management within the MAT program at Mountain Health Center, patients had many successful achievements and realized long term goals they worked hard on. The MAT Program has truly helped patients build and achieve healthy and thriving lives with the support of the case managers and clinicians through the Blueprint. In addition, the WHI program has seen success and appreciation from patients. The WHI Social Worker has indicated the number of patients who "can't believe that this service is available through OB/GYN office, that it is free and that it is relatively easy to get an appointment in a timely fashion. Many patients have been looking for mental health support for months or more and can't find providers in community who are accepting new patients. Patients are so grateful for this resource."

> By no longer being involved with illicit opiate use patients had successes; homeownership, new or first jobs, treated for Hepatitis C, resolved legal issues, achieved high school diplomas, started college, enrolled in job trainings, gave birth to healthy babies, some started regularly attending PCP visits and so many more successes
>
> – MAT RN Case Manager.

Achievements & Accomplishments
Continued

Broadly, the Community Health Team at the local PCMHs have supported many individuals with various needs and concerns and found ways to get them connected or meet their needs directly! Often times, the CHT staff are the first to address deeper concerns that may not have been brought up in Primary Care. For example, if a patient screens positive for a PHQ2 and PHQ9, patients are referred to the CHT Behavioral Health Clinician. During their visits with the clinical, it is often the first time they have discussed their trauma or history with anyone. Similarity, patients are often referred for weightless to the CHT Registered Dietitian, but often the conversation is related to various education or understanding that patients have not heard through other avenues during their care. This sometimes includes gastrointestinal information, debunking dieting culture myths and harms to the body, food insecurity and sometimes eating disorders.

Lastly, another major part of the community health team is supporting quality improvement and meeting patient satisfaction and needs. Middlebury Family Health routinely utilizes a survey to poll our patients on areas that we need to improve on. One area that many practices are currently struggling with is patient access and access to acute care. Patient access can mean wait time or simply being seen when you would like to be seen, often that day. Our baseline survey was conducted through CAHPS (Consumer Assessment of Healthcare Providers and Systems). Our baseline result for patient access was 62%.

Future Goals

On a monthly basis through the Accountable Community for Health and the Adult and Youth Local Interagency Team Meetings, care teams meet and ensure everyone has up-to-date information and provides advice on situations. Additionally, the service provides are continuously improving and encouraging Release of Information to streamline services and communication.

As for the APM Goals, the community is working on all three sectors. The Community Health Improvement Plan 2022-2024 identified all as a priority in various ways. Under Mental Health, the “Zero Suicide” efforts were mentioned and the grants have further supported conversations and collaboration to work towards this goal. Similarly, Access to Healthcare is a priority for the area and the practices are looking at redesigning care to ensure folks are getting their needs met from a team-based care perspective. Lastly, Chronic Diseases is a continuous priority and as a community, we hope to do more programing and support around healthy foods and physical activity through Veggie Van Go and a variety of other supports.

> Seeing this issue and listening to the struggles of our patients, we pulled our resources and hired an acute provider specifically to meet the needs of our community. We set our goal at 75%. At re-measurement 3 months later, our internal survey resulted in a score of 95%. The practice saw a 33% improvement on patient access to care
>
> \- Practice Manager.

Morrisville Health Service Area

Program Manager: Hannah Ancel

19,364	Heath Service Area Total Population
16,156	Blueprint Practices Patient Attribution
10.37	Community Health Team Staff Full Time Equivalents (FTEs)
4.40	Spoke staff FTEs
0.5	Women's Health Initiative Staff FTEs
1,802	Community Health Team Patient Count (January - September 2022)
284	Spoke-Eligible Patient Population (Average August -October 2022, Medicaid only)

Community Health Team

In the Morrisville health service area, we have put care coordination as central to the role for all Community Health Team members. The multidisciplinary team is rich in diverse and deep expertise they can offer to fill the gaps in patient care as needed. The team has a range of specialties including nursing, social work, and dietetics to warp around the complex needs of patients and form a team with the practice providers.

As the Blueprint administrative entity, Lamoille Health Partners FQHC employs CHT members to embed in Lamoille Health Partners practices in Stowe and Morrisville as well as The Women's Center for WHI. We also pass funding through to independent practices to employ care coordinators. Given the large number of patients at Lamoille Health Partners who need CHT support, we have chosen to allocate some of our PCMH funding in addition to the allocated CHT funding to grow the Community Health Team.
The structure for MAT care coordination positions is also a combination of embedded staff and pass-through funding. We currently collaborate with eight clinics and deploy a total of five full time

Primary care programs with robust Community Health Teams clearly can provide full spectrum care, more efficiently with everyone working at the top of their licenses. I do not think I could go back to a time when we did primary care without the CHT. From helping a patient with diabetes to inducting someone into our MAT program, to assistance with meals, transportation, housing, and insurance, the CHT team is really providing the foundational support for patients to actually succeed in meeting their medical goals.

- Dr Katie Marvin, Family Physician & Director of Family Medicine

Achievements & Accomplishments

Our dedicated Hospital Follow Up Specialist position has enabled consistent outreach to patients who were seen in the emergency department to support them in understanding their discharge instructions, reconciling medications, scheduling follow up appointments and resolving unmet social needs. As a result of this work, we see almost no patients continuing to have high ED utilization (3 or more visits in 3 months) from one quarter to a next.

The MAT team has worked to expand access to Sublocade (injectable extended release buprenorphine) across our HSA and are now able to offer this medication at five out of eight locations, making MAT more manageable for patients. Through our community partnerships and an investment in promotional materials we have been able to reach new agencies and providers with education about MAT and local treatment options. We have a new practice, Johnson Health Center, which has increased services in a rural area that previously had very limited resources. Our MAT Program Manager has worked in collaboration with the medical directors at Lamoille Health Partners to develop a resource guide for practitioners about treating chronic pain, reducing long term opioid prescriptions, and identifying substance misuse. This has been a helpful resource for new practitioners who are inheriting patient panels.

Our Blueprint Program Manager, MAT Program Manager, and CHT Lead have provided leadership on developing a training series and workplan to advance health equity.
Key work involved multiple parts of your Blueprint team (PCMHs, Facilitator, CHT) and community partners.

Our Blueprint Program Manager, QI Facilitator, CHT Lead, PCMH Quality Director and mental health agency are developing a workplan for Zero Suicide strategies to increase suicide risk screening in primary care and standardize the pathway to treatment. With the partners, structure and funding coming together with the Zero Suicide mini grant we are making more progress than ever before.

Morrisville Health Service Area

Continued

Key QI Work

Central to the evaluation of Blueprint programing, every year each practice sets rigorous goals and measures as part of NCQA PCMH certification. We have successfully implemented a quality improvement project for depression screening and follow up across all our Blueprint QI supported Patient Center Medical Homes and have seen improvement for all practices. We are working through collaborations to established clear pathways to mental health services. Other universally embraced quality improvement focus areas are care coordination and healthcare costs. All practices are currently engaged in expanding care coordination measures for follow up on specialty referral and emergency department visits. This year all offices with an electronic medical record have started transitioning to using standardized Center of Medicaid/Medicare (CMS) measures for reporting performance to align with upcoming NCQA requirements and further uniform data.
We have established strong collaboration with the Vermont Department of Health immunization program to identify and jointly develop immunization quality improvement projects. We are currently in the planning phase of an influenza immunization program improvement with one of our practices.

> "Having worked across many settings, one of the common threads that weave through all communities is access and availability of care. Having blueprint funded positions decreases barriers by supporting people where they are at and providing the resources and tools to remove barriers like transportation, food insecurity, and insurance."
>
> - Keira Gann, Community Health Team Member

Future Goals

At Lamoille Health Partners, CHT Care Coordinators are identifying patient panels with providers based on social and medical complexity to establish a proactive schedule of co-visits with the patient and their PCP. This allows for CHT to support the patient in identifying and communicating their goals to the provider, create a care plan as a team, and solving barriers. How will you support APM goals of chronic disease management, reducing deaths by overdose/suicide, and assisting patients accessing primary care and specialty care.

We are seeing that our outreach and community education efforts are increasing awareness of resources for those who are at risk of overdose. Our goal continues to be to reduce barriers to accessing care regardless of what stage of change someone may present in. Our Hospital Follow Up Program has helped us make connections with those who have experienced a recent overdose but may have declined support in the ED. We have integrated in Columbia Suicide Severity Rating Scale into the MAT Team screening process and collaborate with our Behavioral Health Team to provide CAMS treatment when applicable. With this in addition to our Zero Suicide workplan for primary care we will be screening and addressing suicide risk at many points of contact.

The unique flexibility and stability of Blueprint funding allows our team to serve any patient whose needs are not met with billable services alone. This includes a diverse patient community who have both medical and social needs. Many of the patients we serve fall in the gap of having income that is too high to qualify for support programs, including insurance, and yet cannot afford to cover their expenses. Time and time again we are told that without support from CHT patients are not sure where they would have gotten help. The ability to remove barriers for anyone, regardless of insurance coverage, is at the heart of health equity.

- Hannah Ancel, Blueprint Program Manager

Newport Health Service Area

Program Manager: Megan Marquissee

20,501	Heath Service Area Total Population
14,907	Blueprint Practices Patient Attribution
2.65	Community Health Team Staff Full Time Equivalents (FTEs)
2.2	Spoke staff FTEs
1	Women's Health Initiative Staff FTEs
985	Community Health Team Patient Count (January-September 2022)
115	Spoke-Eligible Patient Population (Average August -October 2022, Medicaid only)

Community Health Team

The Newport HSA Community Health Team consists of RN and clinical care coordinators, social workers, dietitians, respiratory therapy, a community health coordinator, and other specialty trained staff that are embedded in primary care and specialty practices. Primary Care Newport, Primary Care Barton/Orleans, North Country OBGYN and North Country Pediatrics all have embedded staff in their offices. These practices are all owned by North Country Hospital and Health System, which enables the team to work seamlessly and collaboratively together and with the inpatient Case Management team. This dynamic approach allows the Community Health team to provide comprehensive care at the time of need, ensuring coordination of care not only throughout the ambulatory setting, but broader care transitions from inpatient to outpatient while minimizing unnecessary delays.

Achievements & Accomplishments

In 2022, the CHT partnered with North Country Surgical to better support high risk patients undergoing surgery. The implementation of this partnership has shown a decrease in unnecessary post-op direct admissions as well as a reduction in surgical re-admissions. This collaboration has allowed the CHT to move beyond coordinating DME and instead engages broader community resources and organizations to ensure patients and their families are fully prepared for surgery all while increasing patient satisfaction and achieving better surgical outcomes overall.

Achievements & Accomplishments
Continued

Newport HSA has prioritized and continued to grow its Mental Health Support, with our Licensed Social workers and partnering with NKHS to better communicate and collaborate with our community's mental health needs. We continue to work with community partners such as OEVNA, SASH, Council on Aging and NKHS to provide care collaboration on high-risk or shared patients. With the addition of WHI in our HSA last year in 2021, we continue to have an embedded WHI worker who engages with high-risk OBGYN patients and helps align needed resources. This team member also provides continued support post-delivery when necessary. The addition of this WHI position has allowed us to continue to grow partnerships with key partners such as Dept of Children and Families. This increased collaboration has proven to be a great addition to the CHT and the services we offer to our community and patients we serve.

Finally, we welcomed a community health coordinator as a trained facilitator for our self-management classes and held several tobacco and hypertension classes, one in partnership with Northeast Kingdom Community Action (NEKCA). This role has also allowed for further community partnership participation. Currently, one workgroup is undertaking a substance use disorder/mental health mapping project addressing "mental health services" and "emergency mental health services," two of the priority health concerns from the 2021 Community Health Needs Assessment.

> The level of community collaboration and willingness to serve patient needs in the NEK continually amazes me.
>
> - Chronic Care Coordinator

Future Goals

Utilize training dollars to support the addition of self-management facilitators and broaden the scope of classes currently offered. Reinvigorate monthly community partnership meetings that will include a program highlight each month. This goal of this group will be to share and brainstorm how to ensure patients have access to wraparound services at the right time and place while reducing duplicative efforts.

Continue work on recruitment and retention to ensure primary and specialty care is accessible for not only attributed patients, but for new patients needing to establish care as well.

> You have taken so much stress off me. I don't know what I would do without you .
>
> – Care Coordination Patient

> I wish I would have reached out to you sooner. You have made such a difference in helping me get the care I need.
>
> – Care Coordination Patient

Randolph Health Service Area

Program Manager: Patrick Clark

10,261	Heath Service Area Total Population
10,716	Blueprint Practices Patient Attribution
4.8	Community Health Team Staff Full Time Equivalents (FTEs)
2.2	Spoke staff FTEs
0.5	Women's Health Initiative Staff FTEs
693	Community Health Team Patient Count (January - September 2022)
73	Spoke-Eligible Patient Population (Average August -October 2022, Medicaid only)

Community Health Team

We utilize an embedded Community Health Team (CHT) model in the Randolph Health Service Area (HSA). Our CHT staff members work within each of our HSA's primary care practices, which includes all Gifford FQHC locations and South Royalton Health Center (SRHC), an independent pediatrics practice. We provide pass-through CHT funding to SRHC to support their CHT Care Manager position. The CHT has a mix of both clinical and non-clinical credentials. Our CHT Care Managers are registered nurses and our CHT Care Coordinators have a variety of non-clinical credentials. We have two Certified Health Coaches as part of the team. Our CHT regularly meets with several local community partners and primary care practice teams to conduct care coordination for mutual patients.

Achievements & Accomplishments

Our CHT, MAT Team, and Women's Health Initiative (WHI) social worker receive many referrals for people experiencing food insecurity. To assist with this, Gifford hosts a monthly VeggieVanGo event which continues to see a high turnout. We partner with the Randolph Area Food Shelf to offer emergency food bags to individuals and families who have an immediate food need. These emergency food bags buy us a little bit of time to help people connect to longer term resources. We have Everyone Eats meal sites in two of our practices. We have also partnered with our local transportation agency to deliver meals to homebound individuals. We have a community-wide Clinical Quality Improvement Workgroup as part of our local Accountable Community for Health. This workgroup partnered with our local transportation agency to develop a campaign to educate community members on the importance of prediabetes screening. They created signage and educational tools to post in our local buses which encourage people to take a quick online prediabetes screening tool on the myhealthyvt.org website.

Achievements & Accomplishments
Continued

As the campaign was being developed, the Vermont Department of Health decided it should become a broader statewide campaign instead of just a local campaign. The project launched in September and includes bus posters, wall posters, small rack cards, local radio ads, social media posts, and outreach to providers. These marketing tools contain a QR code to easily connect community members with the online prediabetes screening tool and a direct link to sign up for free diabetes prevention programs.

Future Goals

Our CHT conducts monthly shared care team meetings with the Clara Martin Center, our local designated mental health agency, to coordinate care for mutual patients. We also hold monthly Support and Services at home (SASH) shared care team meetings which include a number of other community partners who are part of the SASH participants' care teams. We hold individual care team meetings at our primary care practices as needed to develop plans for primary care patients. Our CHT works closely with the emergency department and inpatient discharge planners to help provide a seamless experience across the continuum of care. Gifford has been participating in the Vermont Department of Health 1815 grant over the last four years. This work has been focused around developing protocols to help prevent and manage diabetes and cardiovascular disease, with an emphasis on rural, low income, high burden populations. The CHT has been directly involved in this grant work by conducting outreach and offering wrap-around supports to individuals disproportionately impacted by hypertension and diabetes in a negative way. The CHT's efforts have resulted in fewer individuals being overdue for chronic disease management services and improved clinical outcomes for these populations. As part of our participation in the Zero Suicide initiative, Gifford has trained our staff to

Randolph Health Service Area
Continued

conduct suicidality screening universally in our primary care, inpatient, and emergency department settings. Our CHT, MAT Team, and WHI social worker assist patients in accessing mental health resources and ensure that patients do not fall through the cracks. We partner with the Clara Martin Center to provide emergency mental health crisis supports when needed. Our Gifford Addiction Medicine practice offers free Narcan and Fentanyl test strips to any community member who requests them. Our MAT Team reaches out to new prospective patients with a goal of getting them scheduled within 72 hours of receiving the referral. We continually educate community partners on the ease of treatment access, and encourage them to help spread this message to individuals who may be considering treatment. We continue to participate in Rapid Access to Medication Assisted Treatment (RAM) in both the Berlin and Randolph areas. Primary care access continues to be an ongoing, widespread issue. As a Federally Qualified Health Center, Gifford is always open to accepting new patients and works closely with patients to try to make that transition as smooth as possible. We were able to add a small number of new primary care providers in our HSA over the last year. Our CHT conducts outreach to people seen in the Gifford Emergency Department with no primary care provider and offers assistance in establishing primary care. Our MAT Team and WHI social worker offer the same assistance for Addiction Medicine and Women's Health patients who lack a primary care provider.

> Our practice's CHT Care Coordinator is available for patient or provider support at the drop of a hat. He is an integral part of care management for our patients with complex medical conditions.
>
> \- Gifford Primary Care Nurse Practitioner

Rutland Health Service Area

Program Manager: Kathy Boyd & Merideth Drude

43,867	Heath Service Area Total Population
32,026	Blueprint Practices Patient Attribution
8.23	Community Health Team Staff Full Time Equivalents (FTEs)
7.5	Spoke staff FTEs
1.5	Women's Health Initiative Staff FTEs
2,571	Community Health Team Patient Count (January - September 2022)
384	Spoke-Eligible Patient Population (Average August -October 2022, Medicaid only)

Community Health Team

The Community Health Team in the Rutland Health Service Area utilizes several models to meet the needs of our patients, practices, and community at large. The Core Community Health Team are Rutland Regional Medical Center employees, filling the roles of Social Work/Behavioral Health staff along with a RN Case Manager. Two of these positions, the RN Case Manager and a Social Worker, are located in a RRMC office setting and focus on the adult population. They perform home and community outreach visits. The other two Social Workers are embedded within the FQHC Pediatric Practice. The additional two FTEs are supported with pass through funding to assist the Care Managers within the FQHC practices of Community Health Centers of the Rutland Region. Pass through funding also supports Panel Management in the other designated Patient Centered Medical Homes (Associates in Primary Care, Drs. Peter and Lisa Hogenkamp, and Marble Valley Health Works).

The ability to use varying staffing models represents the overall goal of the Blueprint, which is to meet the unique needs of the local community. As each of the Patient Centered Medical Homes has a unique structure, one being a FQHC, one an independent family practice, another solely Nurse Practitioners, and a concierge practice, our staffing model allows the ability to meet the needs of the practice and their patients. Additionally, our staffing model also supports the pediatric and adult population, with designated staff that possess the knowledge and skills needed to support the unique needs of these patient panels.

The Women's Health Initiative (WHI) is also active in the Rutland Health Service Area, supporting the Rutland Women's Healthcare practice as well as the Rutland Planned Parenthood of New England practice site. Rutland is the sole remaining Health Service Area that provides a contracted Behavioral Health Specialist to support the Women's Health Initiative. The value of the WHI effort in addition to the patient centered approach is to support the complexity in navigating the community services and resources that are identified in the Social Determinates of Health screening. The Rutland Women's Health

Community Health Team
Continued

practice also supplies an enhanced screening to also address increasing suicidality rates by asking the first two questions of the Columbia Suicide Severity Rating Scale. The current average positive response rate is 4% regarding suicidality, the Behavioral Health Specialists can assess for safety as well as access to Behavioral Health services, and develop a Safety Plan with the patient that can be shared with established providers.

SPOKE services in the Rutland Health Service Area has added a new practice. Forensic Consultation and Counseling became a SPOKE practice in July. The additional practice is providing an opportunity to improve current workflows and collaboration within the HUB and SPOKE model. One area of specific focus to better enhance our HUB & SPOKE services is to enhance Rapid Access to Medication. The teamwork between our local Turning Point and the Emergency Department has greatly supported the Peer Recovery Coach role in supporting our patients and community regarding access to treatment and other supports.

Rutland Regional Medical Center also provided the ability to address and support the needs for the patients attributed into the ACO Medicaid Expanded panel of patients with the Rutland HSA through the hiring of a Care Coordinator that works collaboratively with the Emergency Department and members of the Core Community Health Team. The goal of this position is to support access to Primary Care as well as address Social Determinants of Health needs and navigation of supports to address those needs.

> "These supports benefit patients practically, but also aim to place patients at the center of their own care, empowering them to make their own decisions about supports and referrals. We see the trust this builds with patients over time, enabling WHI staff to assist patients with areas of need"
>
> \- WHI Behavioral Health Specialists

Quality Improvement

Quality Improvement efforts- all Rutland Health Service Area practices have maintained their Patient Centered Medical Home recognition. Each practice also focused on overall Care Management, both through internal practice-based workflows and utilization of Community Health Team Care Coordination.
Another improvement this past year was the completion of the initial phase to better enhance data collection and analysis of the Community Health Team. The Core Community Health Team is now able to identify now the number of unique patients served by the Core CHT, and direct and indirect care coordination contact with patients, community partners, and providers. This data provides a more comprehensive scope related to the complexity and intensity associated with care coordination.

Rutland Regional Medical Center also provided the ability to address and support the needs for the patients attributed into the ACO Medicaid Expanded panel of patients with the Rutland HSA through the hiring of a Care Coordinator that works collaboratively with the Emergency Department and members of the Core Community Health Team. The goal of this position is to support access to Primary Care as well as address Social Determinants of Health needs and navigation of supports to address those needs.

Future Goals

The goal of the Community Health Team and overall Blueprint efforts within in the Rutland Health Service area is to continue efforts to streamline care coordination within the community. Through better data analytics, education, orientation on-boarding, and enhancing the staffing and capacity of our Community Health Team, our goal is to support strengthening the efforts of Blueprint and Care Coordination. We will continue to enhance the care coordination and community collaboration in support of Rutland being a healthy and thriving community.

Springfield Health Service Area

Program Manager: Tom Dougherty

20,141	Heath Service Area Total Population
11,702	Blueprint Practices Patient Attribution
5.75	Community Health Team Staff Full Time Equivalents (FTEs)
2.1	Spoke staff FTEs
0	Women's Health Initiative Staff FTEs
1,220	Community Health Team Patient Count (January-September 2022)
101	Spoke-Eligible Patient Population (Average August-October 2022, Medicaid only)

Community Health Team

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

Achievements & Accomplishments

2022 found the Community Health Team (CHT) working especially hard to address the particular challenges of the Covid19 pandemic as it stretched into its third year. This meant extraordinary efforts to re-connect with individuals and families who had disengaged from health care and included special outreach efforts to get children in for developmental screening and vaccinations. Similarly, following more than two years of fractured social networks and isolation, the CHT was responding to increases in substance misuse, mental health crises and depression. With CHT support, the Rapid Access service for behavioral health services was expanded, providing a critical link to patients recently discharged from the hospital or disconnected from mental health services.

Achievements & Accomplishments
Continued

These challenges were increasingly acute due to the impact of repeated waves of Covid impacting health center staff, and this on top of the worst staffing shortages in many years. CHT staff responded by covering gaps in staffing to ensure care remained accessible and team members could be supported. 2022 also found the FQHC implementing a new electronic health record, bringing with it opportunities for improved service and efficiency, but also major workflow adjustments and the challenge of learning new technology.

On the Quality Improvement front, the CHT, working closely with our QI Practice Facilitator, was again essential in enabling all primary care practices in the HSA to be recognized as Patient-Centered Medical Homes (PCMHs). As part of the PCMH work, CHT-supported QI teams recorded improvements in key screening rates for breast and colorectal cancer, in vaccinations and well child visits, and reached a record number of individuals with information and assistance in preventing disease.

CHT's central role the provision of care and promoting health and wellness, in particular to those facing economic barriers is evident in these statements from primary care providers across our service area.

Future Goals

Panel Management, where individuals in need of particular services, or those lost to follow-up are identified and outreached to, remains an essential tool for the CHT in supporting population health, preventing chronic conditions and disease and helping focus services and assistance to individuals with greater social and economic needs or those in greater need of care coordination. In 2023 our CHT will look to tap in to panel management to develop more group visits for individuals with chronic conditions like diabetes and to support lifestyle medicine interventions and plan on working with community partners to pilot "food as medicine" programs. CHT staff will be participating on community workgroups to address the priorities identified in our community health need assessment: equitable access to affordable health care, substance misuse prevention and treatment, access to mental health services, and dental care, and are also involved in the state-wide effort to develop a Community Health Worker workforce. We are very excited about new grant-supported initiatives to deploy our new mobile unit- a fully equipped vehicle including an exam room and counseling space, and in developing a chronic care management program to better support individuals with Medicare to reach their personal health and wellness goals.

> "I wanted to share a few examples of how CHT is a tremendous support to our outpatient care. I have referred patients to our Register Dietician (Alexandra) for support in diet changes specific to new diagnoses and patients have given positive feedback about seeing her and having the time to go more in depth regarding specific foods/recipes to try, online resources available and remaining available if they need to see her again. I depend on our CDE (Mo) for support in behavioral changes regarding diet, medication management and learning how to use supplies for diabetes, especially those patients who have this as a new diagnosis and are overwhelmed with where to start with making changes. I also have a lot of positive experiences in referring patients for support in accessing transportation - either through gas cards, bus schedules or medical rides - it has helped patients come in on a more consistent basis once they have these resources presented."
>
> \- Primary Care Provider, Springfield Health Center

St. Albans Health Service Area

Program Manager: Denise Smith

30,652	Heath Service Area Total Population
21,778	Blueprint Practices Patient Attribution
11.15	Community Health Team Staff Full Time Equivalents (FTEs)
12.55	Spoke staff FTEs
0	Women's Health Initiative Staff FTEs
9,501	Community Health Team Patient Count (January-September 2022)
473	Spoke-Eligible Patient Population (Average August -October 2022, Medicaid only)

Community Health Team

The St. Albans HSA has a dedicated, compassionate Community Health Team (CHT) who works together across organizations to solve complex and often difficult health challenges affecting rural Vermonters. The core belief of the St. Albans Community Health Team is that we are serving our neighbors, our friends, and our family members in achieving their health goals. Our core CHT team is embedded in each of the 12 Patient Centered Medical Homes (PCMH) in our region and is made up primarily of RN Care Coordinators with Community Health Workers and Behavioral Health Clinicians. We partner with our Regional Behavioral Health Designated Agency, Northwestern Counseling and Support Services to provide the expertise and supervision needed for our integrated behavioral health model. We also employ embedded RN Care Coordinators and Licensed Alcohol and Drug Counselors for our Hub and Spoke Program in each of our Primary Care Offices and specialty clinics, including the Howard Center, SaVida, and BAART. This program has increased access to the MAT program in our region immensely for our OUD patients. Currently, our PCMH clinics consist of 2 Pediatric clinics, 2 independent Primary Care clinics, and 8 clinics that are part of the NOTCH, the region's FQHC.

The CHT Team works collaboratively together through our shared goals of supporting our friends, neighbors, and family members in our community. We have 2 monthly care team meetings with the core CHT team members, the MAT team members, as well as the other care agencies in our region, including: home health agencies, long -term care, Age Well, and SASH.

We also have a robust monthly Transitions of Care meeting(TOC). We are currently working on aligning TOC documentation between practices, presenting, and reviewing case studies with different scenarios, and working with the in-patient Case Management team at NMC to improve communications between the hospital staff and PCP offices. We have recently developed a shared document that includes contact information for each of the offices PCP providers, care managers, and Community Health Workers. In addition, our Quality Improvement Facilitator has been integral on our in-patient hospital readmissions team by creating joint QI initiatives between the in-patient and out-patient care management teams and RN care coordinators

Achievements & Accomplishments

The theme of 2022 in the St. Albans HSA was managing change and improving transitions, including the region's two pediatric practices, and two primary care practices. The Blueprint team had to manage the complexity of maintaining PCMH recognition for these practices, as well as ensure that the teams continued to engage and communicate with the CHT team and Blueprint Administrators about the staffing transitions to maintain our team-based care for our region. Our QI work focused on supporting those transitions by working with practices on maintaining their PCMH recognition and organizing the CHT teams for improved communications and knowledge.

In addition, the St. Albans HSA managed to create and execute a 4-month Learning Collaborative to a broad community stakeholder group focused on reducing death by suicide and overdose by developing competencies on building a trauma informed community and creating linkages between community and clinical care.

Finally, the Blueprint Program Manager has been a key stakeholder in creating our region's Accountable Communities for Health, The Grand Isle and Franklin County Collaborative, Adaptable, Inclusive, Responsive, Equitable, and Sustainable "CAIRES" Circle which will be instrumental in implementing the mission of designing health and service systems together with communities to be equitable, responsive, and adaptable.

> I have a handful of patients with private insurance at my site. Those that have been able to access the help of my co-located counselor have been grateful to be able to do so at no cost to them. More than one has shared that they were willing to try it because they didn't have to pay a deductible or a copay.
>
> \- Enosburg MD

Future Goals

We are a small community of providers, RN care managers, and behavioral health professionals who support our friends, neighbors, and family members. We will continue to build trust among each other to provide better care coordination and enhance our care teams by meeting regularly, learning from each other and together, and supporting our shared goals of providing quality care to our community. Through our combined HSA and ACH work, improved and frequent communication, joint decision making, and ongoing HSA-wide Quality Improvement projects, the St. Albans HSA will support our goals of improving chronic disease management, reducing deaths by overdose/suicide, and providing equitable access to primary and specialty care in our region.

> Without the Blueprint RN Care Coordinator funded position in my office, I would never be able to manage the chronic nature and progression of disease in some of my patients. This role is invaluable to the health of my patients.
>
> \- St. Albans MD

> One patient can take up to 12 hours of work in one day. There is no way to quantify the work that we do because of who we serve. They are some of the most vulnerable and most sick of all our population and we are sometimes their only support.
>
> \- Enosburg Care Manager

St. Johnsbury Health Service Area

Program Manager: Katie Bocchino

19,066	Heath Service Area Total Population
14,311	Blueprint Practices Patient Attribution
16.4	Community Health Team Staff Full Time Equivalents (FTEs)
1.8	Spoke staff FTEs
0.75	Women's Health Initiative Staff FTEs
4,245	Community Health Team Patient Count (January - September 2022)
115	Spoke-Eligible Patient Population (Average August -October 2022, Medicaid only)

Community Health Team

The Community Health Team (CHT) is essential to providing quality, coordinated care to patients in the St. Johnsbury Health Service Area. The five Behavioral Health Specialists (BHS), including a BHS Supervisor, and six RN Care Coordinators, are embedded in the Federally Qualified Health Centers and Rural Health Clinics. A Social Worker for the Women's Health Initiative is embedded in the Northeastern Vermont Regional Hospital (NVRH) Women's Wellness practice. The two Mental Health/Substance Abuse Clinician and Spoke RN for the Medication Assisted Treatment program are contracted through BAART to provide Spoke services in the primary care practices. The six Community Health Workers (CHW), including a CHW Lead, are embedded in the primary care practices and also can be accessed at Community Connections, where individuals can ACCESS help from CHWs finding and connecting to primary care and social and community services without having to make an appointment. The CHT meets on a monthly basis to share resources with partner agencies throughout the region. The St J HSA holds two other monthly meetings during which partner agencies throughout the region attend and discuss the Team Based Care approach and to identify solutions and system-level changes to gaps and barriers in care. The support that CHT staff offer to patients often goes beyond the immediate need that a patient presents with. An example of this this can be shown by the outcome of a recent referral to Community Connections, which was for a glucometer but resulted in the patient instead getting connected to ongoing healthy food access. The CHW at Community Connections began working with a patient after receiving a referral for help paying for a glucometer to help them manage their diabetes. In completing the intake which includes questions related to Social Determinants of Health, the CHW realized that although the patient was likely eligible, they were not connected to 3Squares. The patient said they had previously applied but were not eligible, so the CHW offered to look into it for them and discovered that the patient had not checked the box to be screened for eligibility. As a result, the patient was connected to 3Squares. The patient reported they felt not only could they could eat healthier, hoping eventually the glucometer would not be needed, but also that they could now afford to pay for the glucometer themselves if they did end up needing it.

Achievements & Accomplishments

Northern Counties Health Care (NCHC) and NVRH have many achievements that we are proud of, several of which are a collaboration between the two organizations. Both NCHC and NVRH remain focused on diabetes and hypertension as a key clinical focus through the CDC/VDH 1815 grant-related work. Patients are continuing to make beneficial lifestyle changes, lose weight and build a support system. Providers have more tools to support patients to prevent and manage diabetes, and it is making a real difference. Highlights of this work include development of diabetes, hypertension, and cholesterol screening and management protocols; offering Continuous Glucose Monitoring and Team Based Care for Management of Diabetes; NCHC continued the blood pressure cuff lending program; and NVRH integrated the ASCVD Risk Calculator into the EMR. Additionally, NVRH is promoting evidence-based practice for patients through the grant, focused on hypertension prevention for individuals ages 25-35 by increasing awareness off risk factors and how to modify lifestyle to prevent hypertension and other negative outcomes.

NCHC created a Pre-Visit Planner and a Quality Reporting Folder, both done in collaboration with Bi-State Primary Care Association. The Pre-Visit Planner in particular has been very successful. Prior to its creation, all visit preparation was done through tedious, manual chart review. The Pre-Visit Planner auto-populates many items from the EMR into a one page document, saving nursing staff considerable time prepping for visits and helping to ensure that preventative screenings are not missed. All providers now have access to a Quality Reporting Folder which gives them real-time data on patients that are due for cancer screenings, patients with diabetes and prediabetes who's most recent recorded A1C is greater than 9, and patients that have diabetes but do not have a recorded A1C in over 365 days.

St. Johnsbury Health Service Area

Continued

The reports allow for clinical staff to incorporate targeted outreach and follow up into their daily schedule.

NCHC piloted a centralized triage nurse position that covers calls for multiple sites, which was so successful that a second triage nurse has since been hired. NCHC expanded Community Health Workers into the dental and Express Care sites, giving patients that are not enrolled in primary care services through on of the NCHC sites access to a CHW. Additionally, Concord Health Center began participating in the Hub and Spoke program this year with a new provider prescribing.

NCHC St. Johnsbury Community Health Center was awarded the 2022-2023 Suicide Safe Pathways Mini Grant. In round two of this grant, NCHC St. Johnsbury Community Health Center will provide more staff education around suicide awareness and using the risk screenings available for patients, andmaking a plan from those screens. NCHC is also working closely with Northeast Kingdom Human Services (NKHS), St. J's Designated Agency, on tracking and completion of referrals. All five NCHC practices, and NVRH's St. Johnsbury Pediatrics, participated in the 2020-2021 mini grant that included staff training in QPR, Counseling and access to lethal means (CALM) and Collaborative Assessment and management of suicidality (CAMS) and collaborative meetings with community partners to improve protocols for suicide prevention and referrals. Collaboration from the first round of funding is also continuing with regular quarterly check-ins that include data review and workflow improvements as necessary.

> "I am ... thankful that I can be part of a team that advocates for and assists folks in whatever capacity we can."
>
> - Community Partner Agency

Achievements & Accomplishments
Continued

Building off the successful work that was done through the 2020 -2021 Suicide Safer Pathways mini grant, the NVRH Emergency Department and Care Management successfully implemented Y-SBIRT (Youth Screening, Brief Intervention, and Referral to Treatment) into the Emergency Department's workflow. This was done in collaboration with St. Johnsbury Pediatrics, where Y-SBIRT is already implemented.

A small task force has been established at NVRH of staff from many different departments with a goal of identifying and making efficiencies within the data collection process to improve the capture of positive depression screen follow-ups for all practices. This multi -disciplinary group has staff from the following areas: Information Services, Community Health Improvement, Blueprint/ACO, Clinicians and the primary care practices. Corner Medical has increased the frequency with which they are performing depression screenings by changing their protocol to include the screening at more than just annual exam visit types, and the other practices are working on strategies to increase their depression screenings. Kingdom Internal Medicine has also been working on strategies to increase their depression screenings.

NVRH developed a Team Based Care model pilot between the Community Health Workers of Community Connections and the Recovery Coaches at Kingdom Recovery Center, which centers around developing a core team to help support people in need of recovery services. This work was made possible through funding from the Prevention Center of Excellence. When a person is identified by a Recovery Coach at Kingdom Recovery Center as someone who could benefit from support accessing available resources, they make a referral to a CHW at Community Connections. The CHW sets up an initial team meeting between the individual, a Recovery Coach, and a CHW.

St. Johnsbury Health Service Area
Continued

Using person -centered tools and strength based, team care model, the participant identifies recovery goals. The CHW and Recovery Coach work with the individual for three consecutive weeks to support the individual in meeting their goals. The Brief Addiction Recovery Capital screening tool is administered pre- and post-intervention and assessed for improvement.

After about a year of working collaboratively with NKHS, NVRH implemented a workflow related to the documentation the NKHS Emergency Services team completes in the NVRH EMR when they are called for mental health support. The new documentation within the EMR ensures that the appropriate releases are signed and embeds the PHQ9, Columbia Suicide Severity Rating Scale, and Counseling Against Lethal Means in the EMR template used by the Emergency Services team.

I don't know how we would care for patients without our Care Coordinators, BHSs or CHWs. Having just had vacancies in a few of those positions, it has made us appreciate even more how these positions add to the wellness of patients.

– VP Medical Practices & Operations, NVRH

Continued on Following Page...

Future Goals

The St. Johnsbury HSA has a robust three-part Team Based Care training curriculum: The Basics of Team Based Care; Team Based Care: Community Partner Engagement and Communication; and Introduction to Team Based Care for Leadership. These trainings are offered to new staff at any healthcare or community partner agency in our region, and we will continue to hold these trainings to strengthen Team Based Care in our community. We will continue building on our success around prevention and management of diabetes and hypertension/cardiovascular disease as reported above including deep community work and interventions to address the root causes of poor health. We will continue training staff to identify and respond to those in mental health crisis and participation in the NEK CAMS-care (Collaborative Assessment and Management of Suicidality) Team, expanding the MAT program, and furthering multi-sector collaborative and community conversations and partnerships around building a comprehensive, accessible, high-quality local mental health/substance use system of care in the Northeast Kingdom. We will continue always ensuring individuals in the Emergency Department, Express Care, or who are discharged from Inpatient are offered a referral to primary care, while also focusing on aggressive recruitment and retention strategies to build and sustain our workforce. We'll also continue making improvements to patients' telehealth experience, expand the Express Care walk-in primary care model, and hire and train more Community Health Workers to help maintain our already strong community and healthcare partnerships and referral workflows to ensure expedited care, whether it be for social determinants or physical healthcare needs.

> The Care Coordinator and BHS are an essential part of the Community Health Team and Kingdom Internal Medicine. Often times, social determinants and behavioral health needs prevent patients from being able to participate in their care. The CHT finds creative ways to help patients work through those barriers which contributes to healthier outcomes. The work that they do with patients allows the clinicians to focus on delivering effective, high quality healthcare.
>
> - Kingdom Internal Medicine Practice Operations Director

Windsor Health Service Area

Program Manager: Jill Lord

30,456	Heath Service Area Total Population
12,632	Blueprint Practices Patient Attribution
7.43	Community Health Team Staff Full Time Equivalents (FTEs)
2.5	Spoke staff FTEs
0	Women's Health Initiative Staff FTEs
1,808	Community Health Team Patient Count (January - September 2022)
326	Spoke-Eligible Patient Population (Average August -October 2022, Medicaid only)

Community Health Team

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

> The Community Health Team is an integral part of our community. We have formed strong bonds with a multitude of partners to ensure our patients overcome barriers to living healthier lives. We meet patients where they're at whether it be in the home, workplace, senior center, or park trails. Patient-centered care is essential in listening to what matters most to the patient and their family. We applaud the embrace the small successes when patients are empowered to take control of their own health .
>
> \- CHT

Achievements & Accomplishments

- Regional coordination improvements for connecting patients to VDH Healthier Living Workshops (HLWs):
- Virtual group meetings have improved participation and access.
- VDH recognized the online linkage to www.myhealthyvt.org [myhealthyvt.org] was notably used by individuals to connect to HLWs. An easily navigated link to help patients and care coordinators connect to virtual classes.

Little Rivers Health Care

The Upper Valley Unified Community Collaborative continues to meet monthly to discuss community health needs and initiatives. In 2022, we established 3 focus topics: transportation, food access, and integrating resources.

- Tri Valley Transit increased scheduled bus routes and added a line connecting Bradford and Fairlee. TVT offered the Rides to Wellness and Rides to Recovery gas assistance programs, which were heavily utilized by patients who requested assistance to get to their wellness and MAT (medication assisted treatment) programs.
- Food Access - Vermont Everyone Eats continued to supply local organizations with frozen meals to distribute to clients.
- LRHC obtained a grant from Bi-State to establish an on-site Food Farmacy to offer food to patients at risk for CVD and experience food insecurity.
- UVUCC uses time in the meetings to coordinate services and hear about programming from other organizations. The coalition sometimes identifies places of overlapping services and coordinates when it is advantageous.

MAT – LRHC currently has 64 patients. A noted positive is in the increase in access, both adding the Bradford location but also the quick timeframe in which they are seen for services.

Upper Valley Pediatrics

A part-time LPN provides care coordination for the practice. Upper Valley Pediatrics developed a strong relationship with our Blueprint QI facilitator bringing education and building capacity within the practice.

White River Family Practice

- Collaborated with Clara Martin Center by having Lisa Cadow meet with patients to facilitate them getting mental health services initiated the CCM program utilizing Dr. Drake's consulting to assist with patients with mental health concerns.
- Worked with The Family Place on early childhood screening/intervention.
- Worked with the Hartford Community Coalition on a variety of initiatives including the "Take a Bite Out of Hunger" summer food program.
- Hosted the community food drive for The Haven this fall.
- Disseminated Community Health Program (Prevent Type, etc.) information to our patients through bulletin boards/verbal communication.

Achievements & Accomplishments
Continued

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

- Having more community partners come to our weekly Care Coordination Meeting, making connections and helping each other with care coordination and resource sharing.
- Helping provide increased resources and referrals for ED patients.
- Formation of a MAHHC/DCF/Health Care and rehabilitation services (HCRS) team that meets weekly to care coordinate high risk pediatric patients in the ED.
- SUD - formed a community collaborative for collective impact, RAM, outreach after overdose, Narcan distribution, anti-stigma campaign.
- Strengthening Families- play groups and Circle of Security parenting groups
- Food security- food drives, food security asset mapping, gardening projects, anti-stigma messaging.
- Housing- support of Home Share working with Thompson Senior Center
- 50+ Network – SUD education, resource education, network formation for Aging in Place groups
- Spiritual Health – Asset mapping project

Windsor Health Service Area
Continued

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

The Community Health Teams are the stars. They provide panel management, care coordination, outreach, referral and integration with community partners on behalf of the individuals and patient populations we serve. These teams work with all ages of individuals and groups providing care in the continuum of prevention through high-risk complex chronic care management. They concentrate their care, education and expertise in the arenas of clinical care encompassing both physical and mental health and the Social Determinants of Health. The CHT provides patient centered care. Some patients require daily intervention (hundreds of hours) which is reduced over time as progress is made toward their unique goals and needs. Other patients require brief targeted interventions to access services for specific goals.

Key QI Work

Key QI work concentrates on the prevention and management of chronic disease, mental health and addressing the barriers to health. As such concentrated efforts have been made to implement best practices in the management of diabetes and hypertension. Key work includes reducing ED and inpatient admissions, reducing deaths by overdose and suicide and improving access to care.

Continued on Following Page...

Future Goals

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

1. Continue to build trusting relationships and improved communication and care coordination among team members.
2. Participate in the Blueprint, mental health and PCMH suicide prevention program.
3. Strengthen the mental health wellness clinic via building a structured relationship between MAHHC and HCRS to provide a facilitated bridge to therapeutic services.

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

The Blueprint for Health is revolutionizing the way we deliver care for individuals and for our population as a whole . This is true health care reform work! We are committed to quality by meeting and exceeding the health care standards set by NCQA as a Patient Centered Medical Home. We have grown our Community Health Teams into local and regional networks to deliver high quality care with our partners in mental health, visiting nurses, Senior Solutions, SASH, etc. This is true patient -centered care that is essential in these challenging times! It is a privilege to be part of building new systems and programs and improve the lives of those we serve. I wish you could see the gratitude in the eyes and hearts of people who regain health and function, of families who have new critical resources that allow them to survive and work to thrive and grateful community partners as they work together. We are making a difference!

- Program Manager

Planned Parenthood of Northern New England (PPNNE)

Program Manager: Kelly Miller

3.5	Women's Health Initiative Staff FTEs
3,381	Attributed Patients Statewide
1,357	Patient Encounters

Community Health Team

The year has been equal parts challenging and equal parts exciting. We currently have fully embedded patient support counselors (PSC) which is what we refer to our CHT as on our Integrated Behavioral Health & Social Work (IBHSW) Program in the Barre, White River Junction, Brattleboro, St. Johnsbury, Williston, and Burlington. There continues to be a patient support counselor located in the Rutland Health Center who is employed by Rutland Regional Medical center and contracted to work at PPNNE Rutland.

Achievements & Accomplishments

Planned Parenthood of Northern New England (PPNNE) made the difficult decision to close 4 of health centers around the state for a variety of reasons in July 2022. The organization experienced unprecedented challenges in the past few years since the 2016 election, through the defunding fight during the Trump Administration, the loss of Title X funding, the challenges of providing time-sensitive sexual and reproductive health care during the COVID-19 pandemic, the nation-wide staffing shortages, and now the loss of Roe v Wade. While the closures were disruptive to communities and the organization, the IBHSW program and health centers alike continued to provide care to patientsAdditionally PPNNE successfully transitioned to EPIC as a new Electronic Health Record. We are currently 5 weeks past go live and things are going well. I would like to highlight that we saw more patients this year than last despite closing 4 health centers.

Collaboration within CHT: It is important to highlight the work that is being done across the state in each county, within each community. The PSC's at PPNNE continue to work with their local CHT teams.

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Planned Parenthood of Northern New England (PPNNE)

Continued

Key QI Work

A formal process we use for QI work is to collect patient satisfaction surveys. I would like to add a few patient quotes.

> "[The PSC] is an amazing ally, support and wealth of knowledge, compassion and empathy. I always feltheard and understood. He went out of his way to make sure all my questions and concerns were addressed. 10/10 would recommend to anyone who needs his services.

> Super helpful on walking me through a confusing and scary process.

> [The PSC] was an invaluable resource and held space in a caring and very helpful way as I navigated so many different difficult dynamics. She was patient, caring, and thoughtful. She has my endless gratitude and appreciation."

We currently collect patient satisfaction forms outside of the system (Press Ganey) PPNNE uses for other services. Our hope is to transition to using Press Ganey for the services offered through the IBHSW program. We are just beginning to learn how EPIC will improve our formal CQI practices. Immediately we have quicker access to information about the number of referrals the IBHSW program is making in the community. We are very excited to see how we can use reporting features in EPIC to cull other useful data.

Future Goals

The goal is for continued use of informal and formal CQI practices to inform the work we are doing in the IBHSW program at PPNNE. As mentioned earlier we have formed informal processes for assessing the work. The informal processes include a regular meeting with the PSCs across the state, and a regular meeting with the PSC's and a representative from the health care delivery team. As always, our goal is to continue to improve and strengthen relationships with community partners and organizations across the state. One of the challenges we have experienced is lack of ongoing mental health care. The designated agencies across the state are short staffed and waiting lists are long. In addition, finding competent providers in the community is challenging. This challenge led us to providing people with bridge services. The bridge service is short term support until patients are connected to the long-term care they need in the community. Not all patients want this service, it is simply offered to increase continuity of care, especially for patients experiencing suicidal ideation. The wait time for services can range from 1-4 months. The work done in this time is focused on skill building and providing psychoeducation about mental health. Visits typically occur every other week or every 3 weeks. We do not provide trauma treatment. We are committed to providinghigh quality short term care and resource coordination to patients.

Jill Lord, RN, MS, Director of Community Health at Mt. Ascutney Hospital and Health Center, served as Blueprint Program Manager in the Windsor Health Service Area from 2010-2022.

Jill Lord is one of the founding leaders of the Blueprint for Health. Since 2010 when she became a Program Manager for the Windsor Health Service Area, she has been an anchor for the program, and one of the go-to leaders to understand how to build Community Health Teams, support primary care, and help Vermonters get the services they need. Her passion to help the citizens in her community is boundless and she has been an energizing force for other community leaders in Vermont.

Jill makes building partnerships look easy with her kindness, savvy, and persistence. She builds the kinds of teams within practices and communities, across disciplines, that truly move boulders uphill.

Health services for all Vermonters are better because of Jill's vision, commitment, and natural leadership skills. We couldn't have more respect for who she is, what she has accomplished, and what she helped the statewide Blueprint for Health network and programs to accomplish.

Congratulations on your retirement! We thank you, Jill!

The Blueprint for Health

December 2022

VI. APPENDIX: EVALUATION MEASURE RESULTS

A. QUALITY MEASURE RESULTS

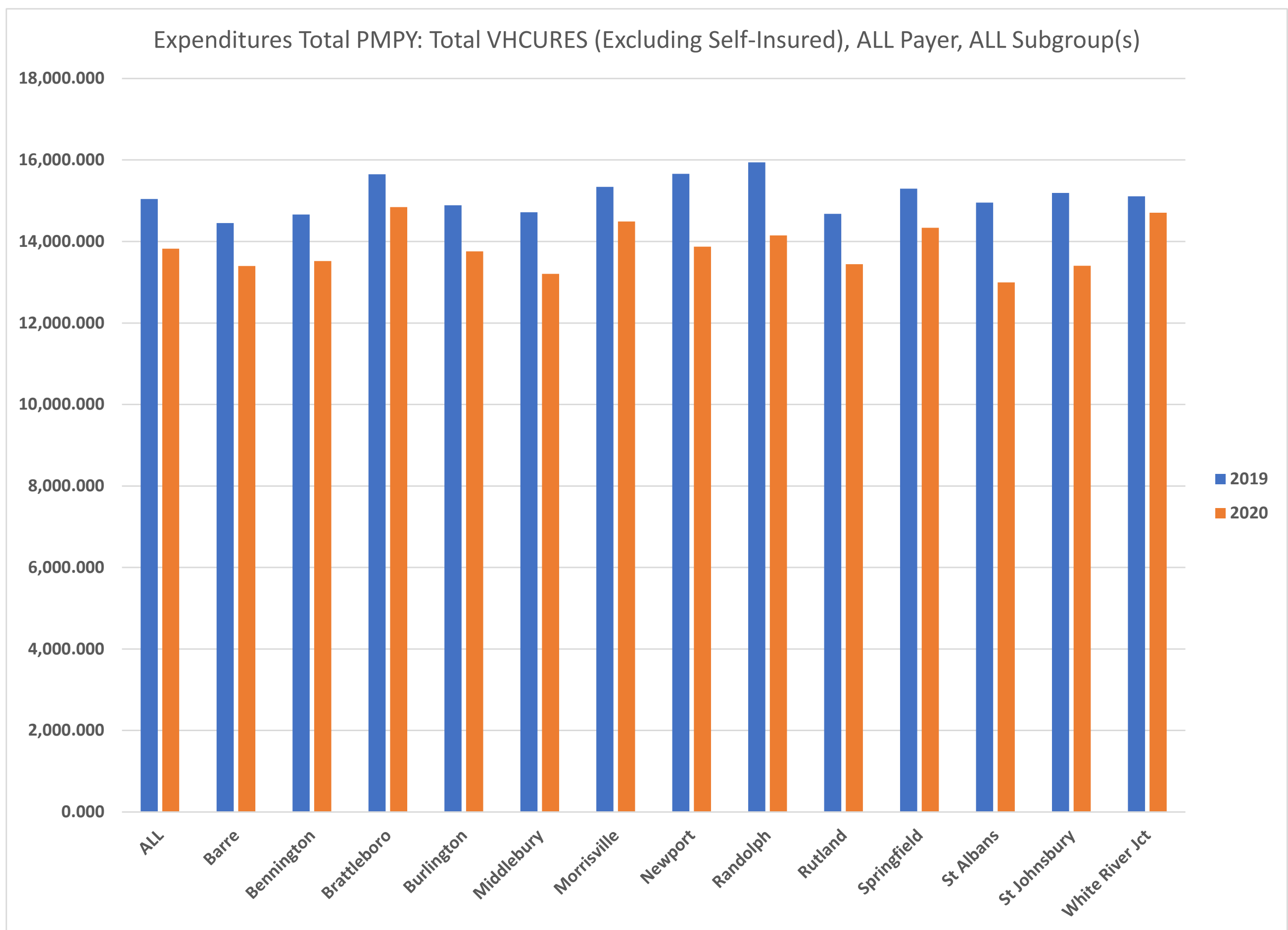
Population N (Person Counts) By HSA:

Total VHCURES (Excluding Self-Insured) Population

Healthcare Expenditures

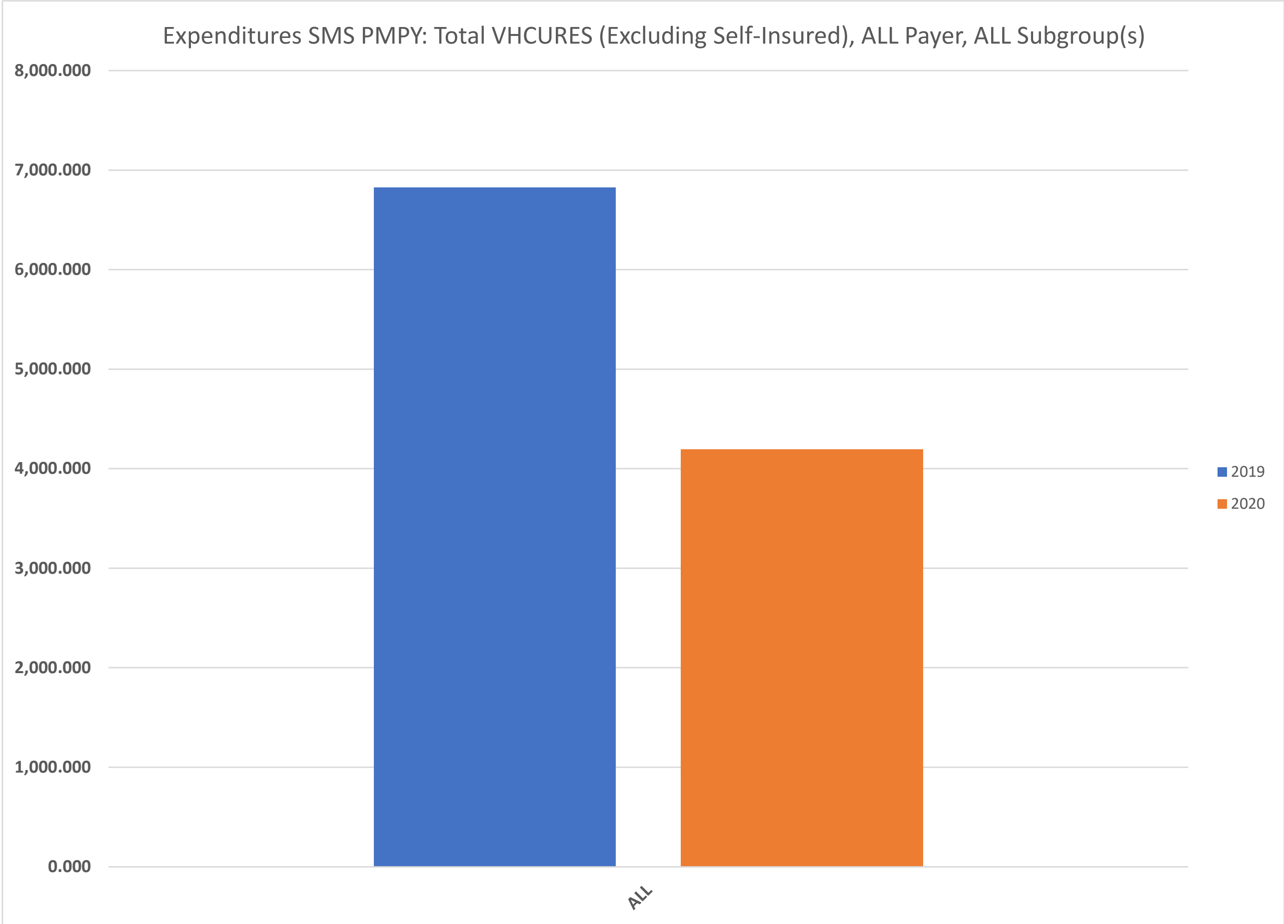
Expenditures Total Per Member Per Year, Risk-Adjusted By HSA (Dollars, Inflation-Adjusted):

Total VHCURES (Excluding Self-Insured) Population



Expenditures Special Medicaid Services Per Member Per Year, Risk-Adjusted, Statewide (Dollars, Inflation-Adjusted):

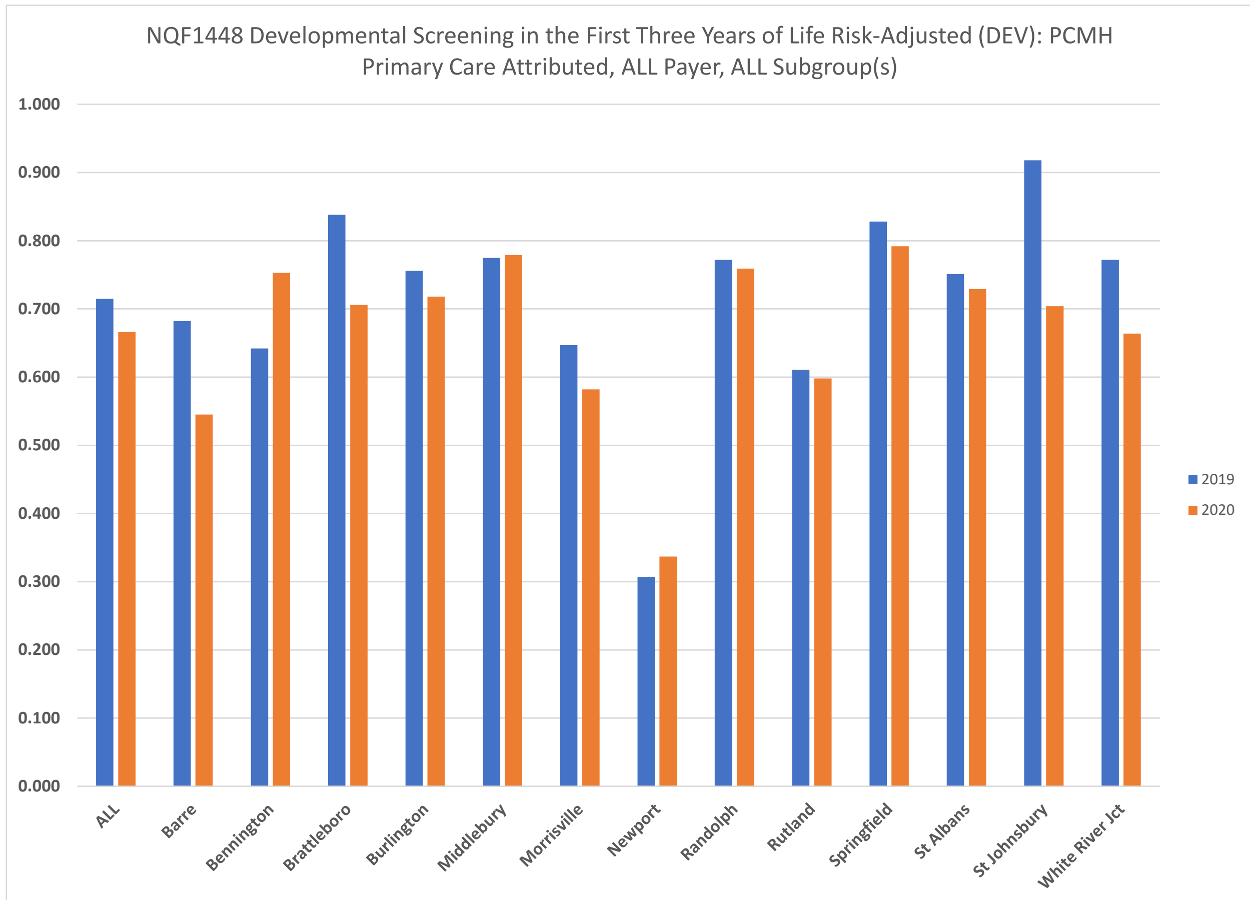
Medicaid-Primary Population



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

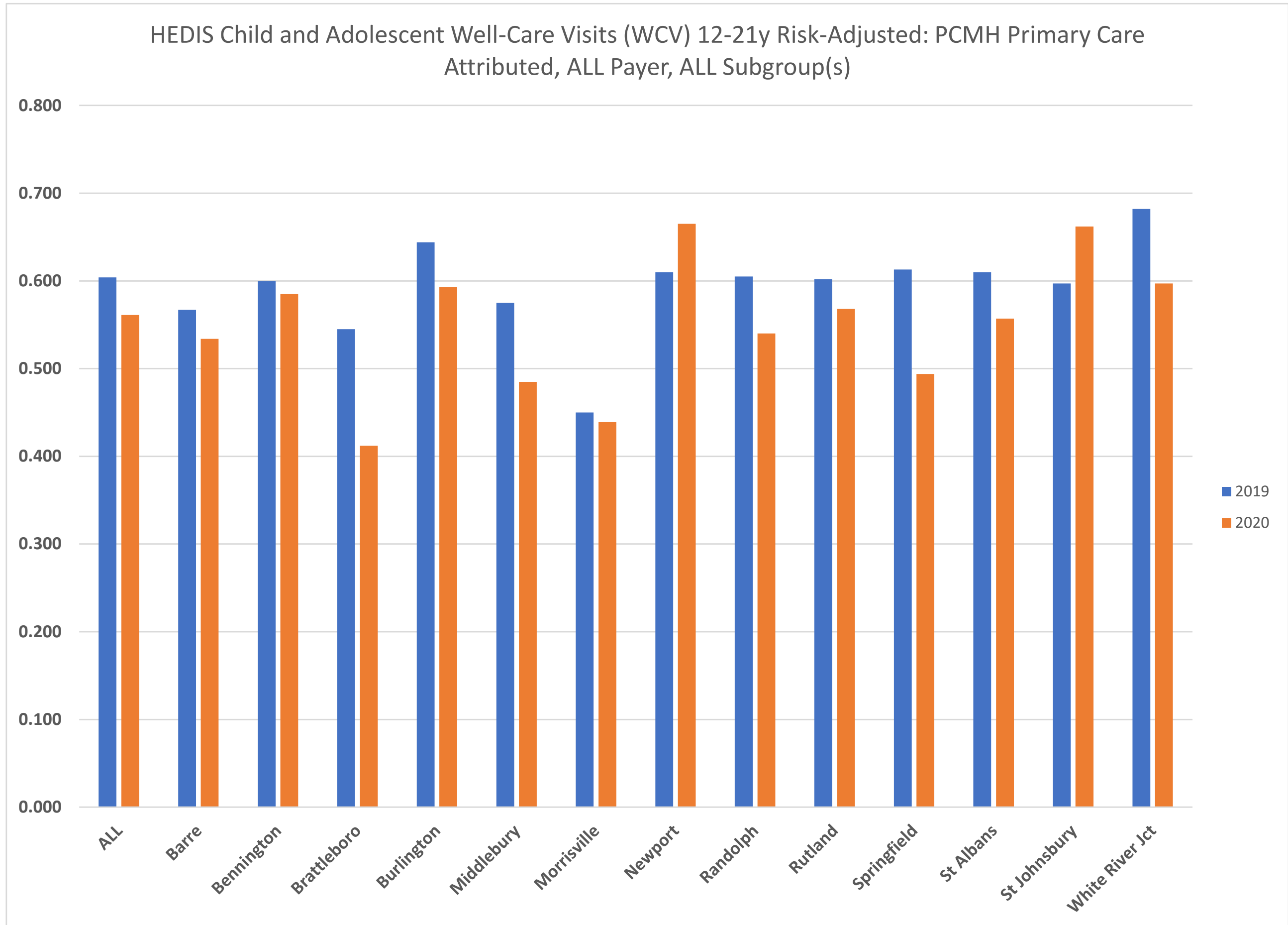
NQF1448 Developmental Screening in the First Three Years of Life (DEV), Risk-Adjusted By HSA (Proportions):

PCMH Primary-Care-Attributed Population



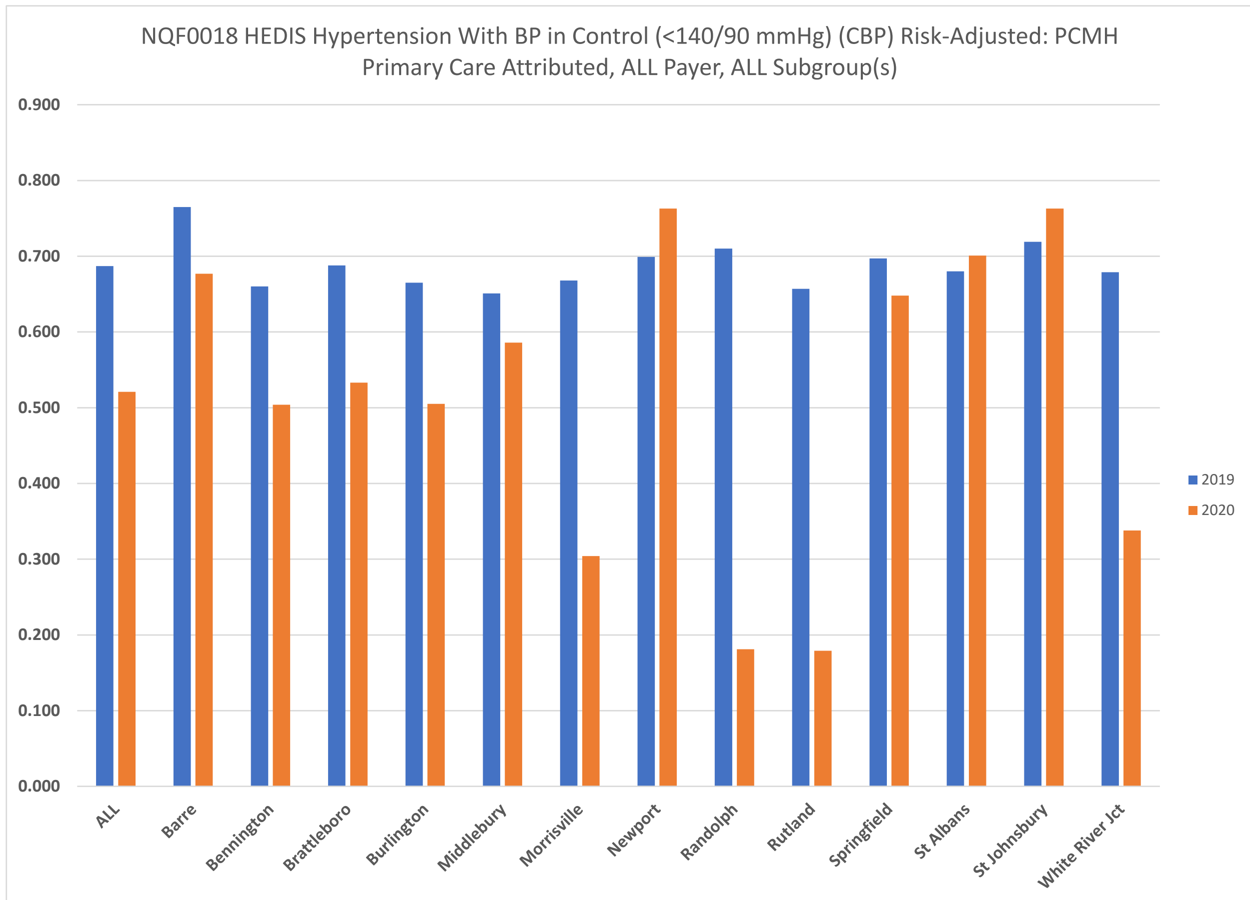
HEDIS Adolescent Well-Care (AWC) Visit 12-21 Years Old, Risk-Adjusted By HSA (Proportions):

PCMH Primary-Care-Attributed Population



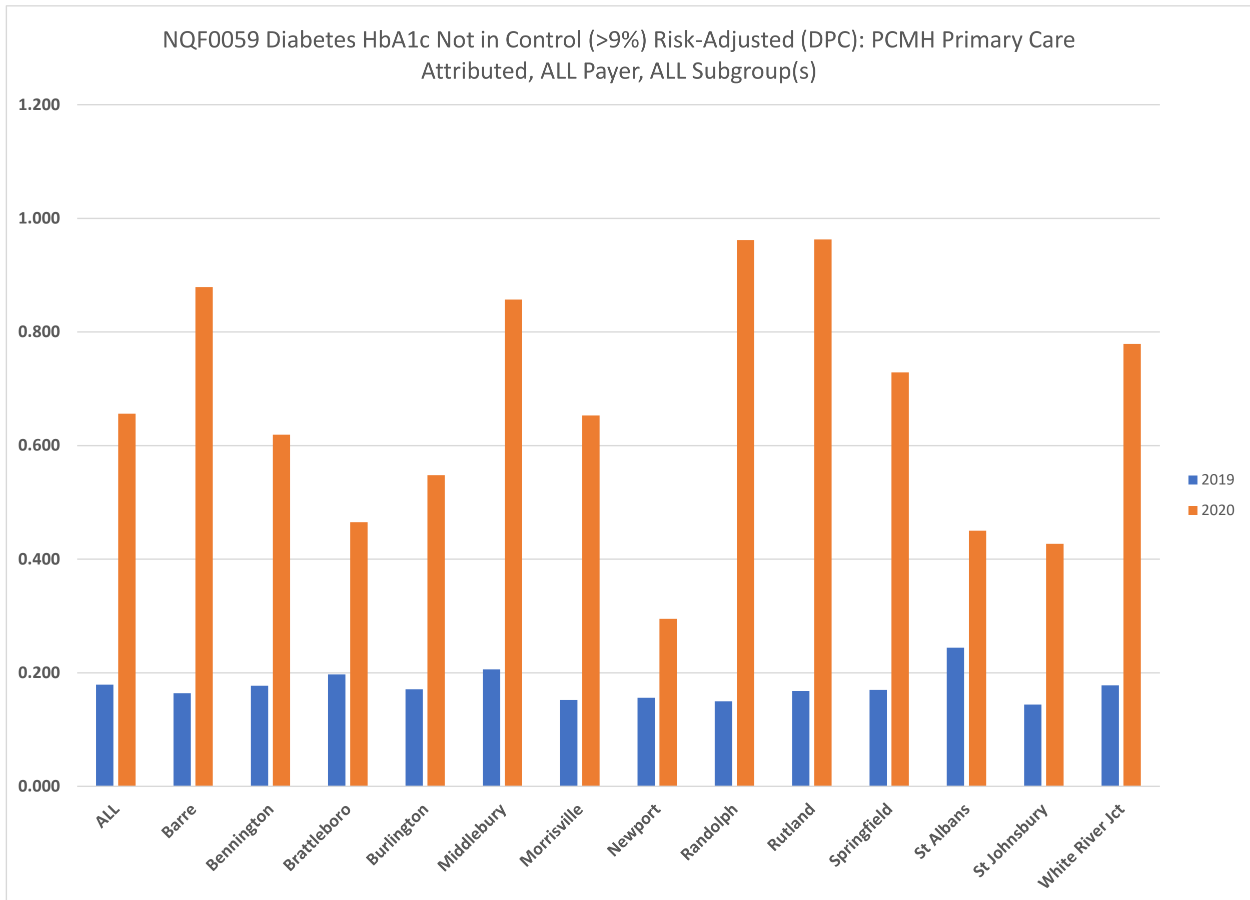
NQF0018 HEDIS Hypertension with Blood Pressure in Control (<140/90 mmHg) (CBP), Risk-Adjusted By HSA (Proportions):

PCMH Primary-Care-Attributed Population



NQF0059 Diabetes HbA1c Not in Control (>9%) (DPC), Risk-Adjusted By HSA (Proportions) [Lower is Better]:

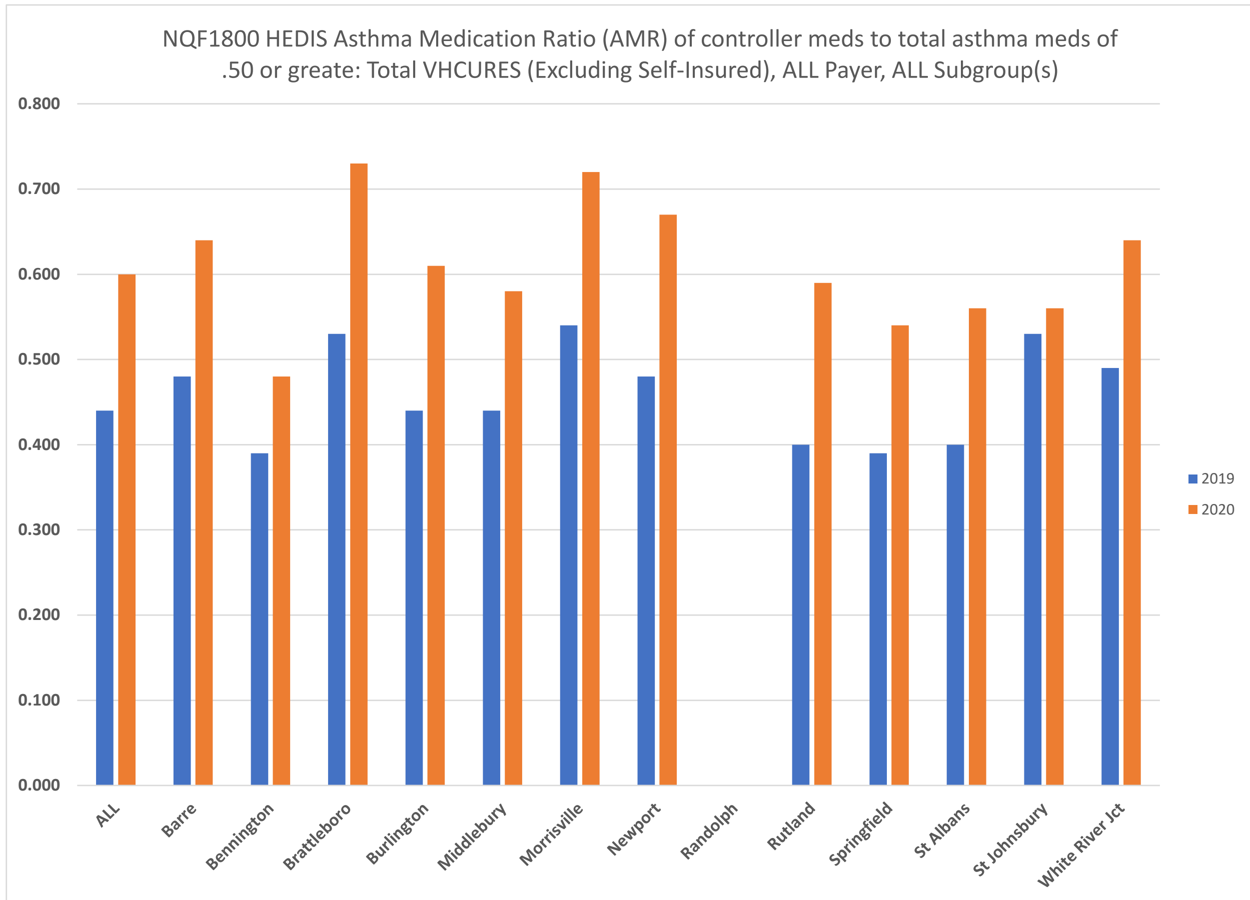
PCMH Primary-Care-Attributed Population



Other Chronic Conditions

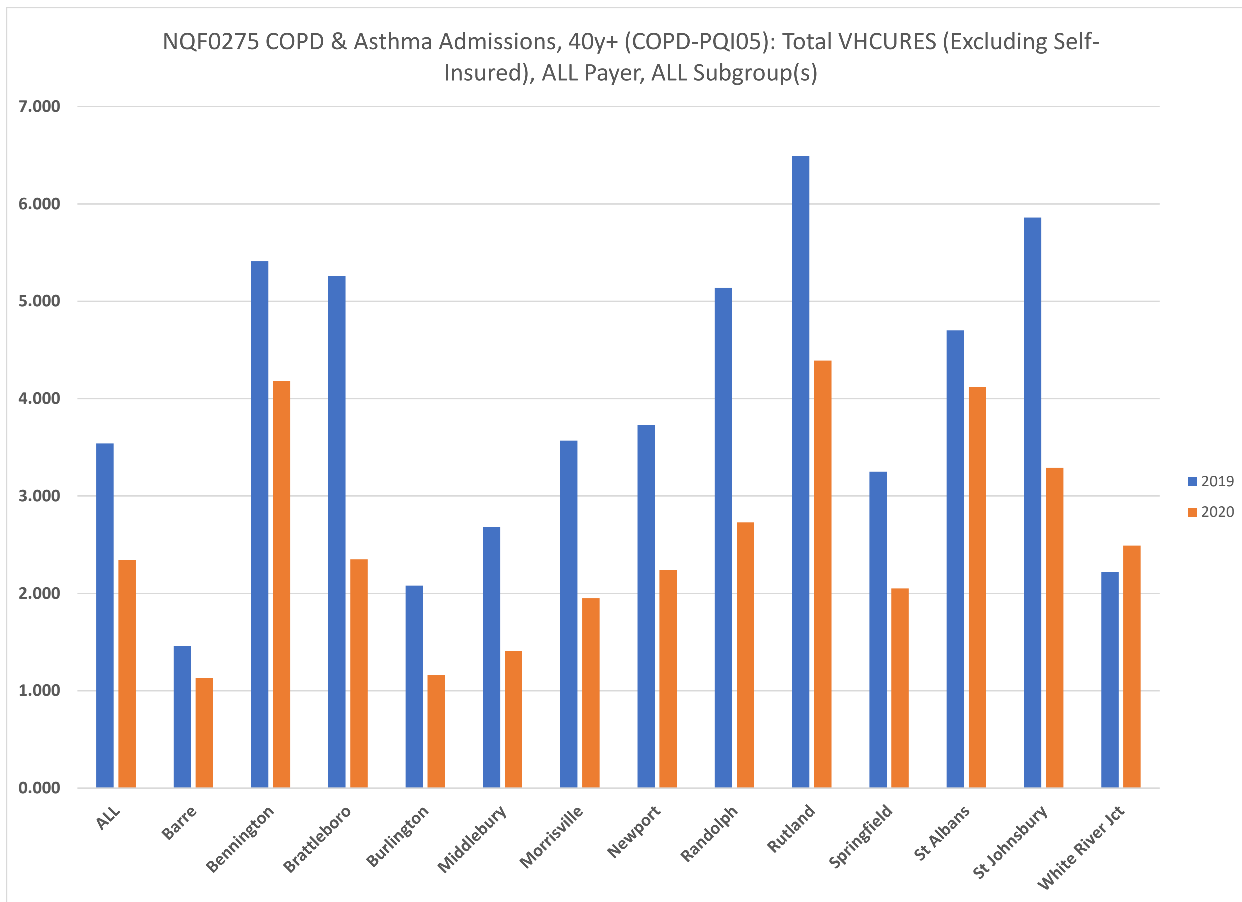
NQF1800 HEDIS Asthma Medication Ratio (AMR) of Controller Medications to Total Asthma Medications of .50 or Greater (Proportions):

Total VHCURES (Excluding Self-Insured) Population



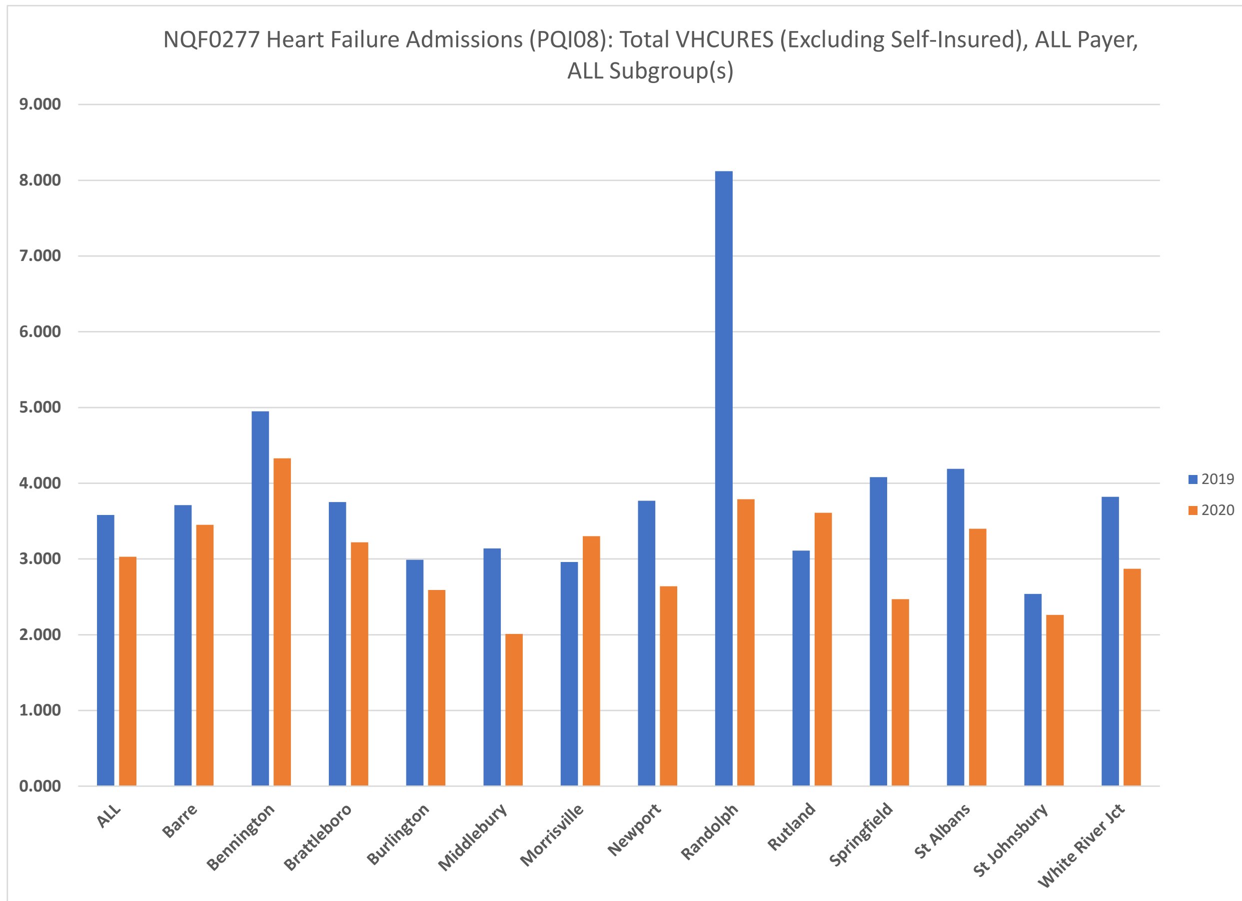
NQF0275 COPD & Asthma Admissions, 40 Years Old Plus (COPD-PQI05) (Admissions Per 100K Population):

Total VHCURES (Excluding Self-Insured) Population



NQF0277 Heart Failure Admissions (PQI08) (Admissions Per 100K Population):

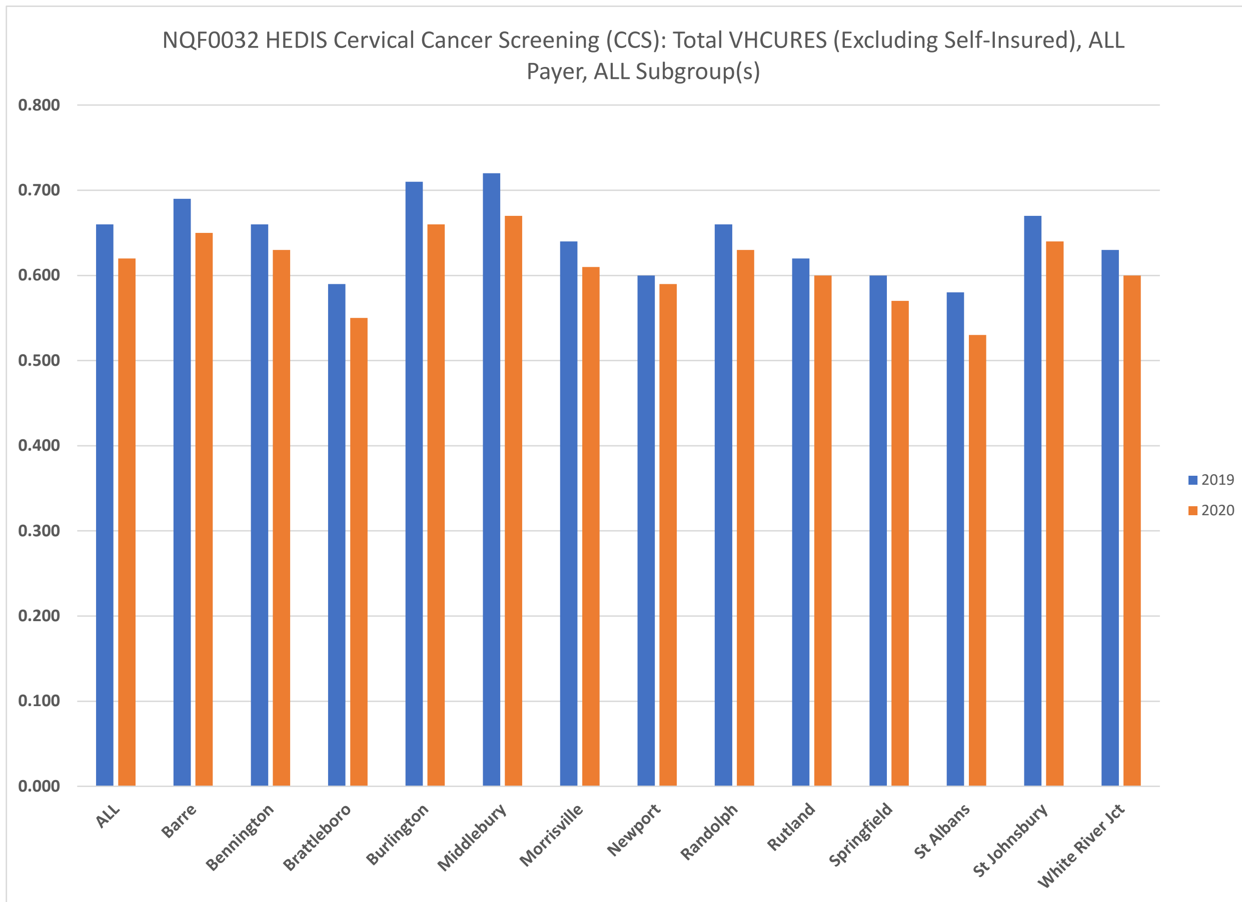
Total VHCURES (Excluding Self-Insured) Population



Women's Preventative Healthcare Measures

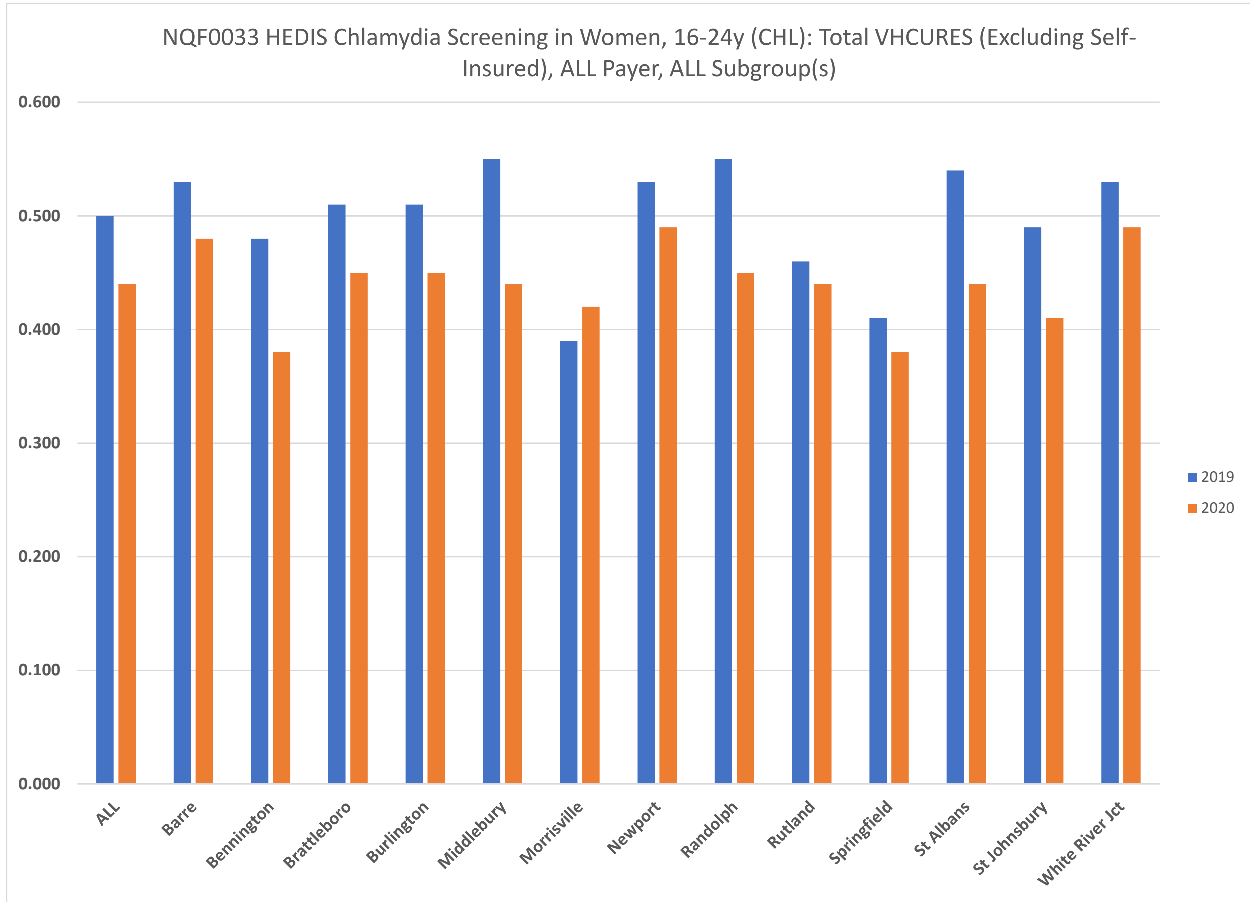
NQF0032 HEDIS Cervical Cancer Screening (CCS) (Proportions):

Total VHCURES (Excluding Self-Insured) Population



NQF0033 HEDIS Chlamydia Screening in Women, 16-24 Years Old (CHL) (Proportions):

Total VHCURES (Excluding Self-Insured) Population

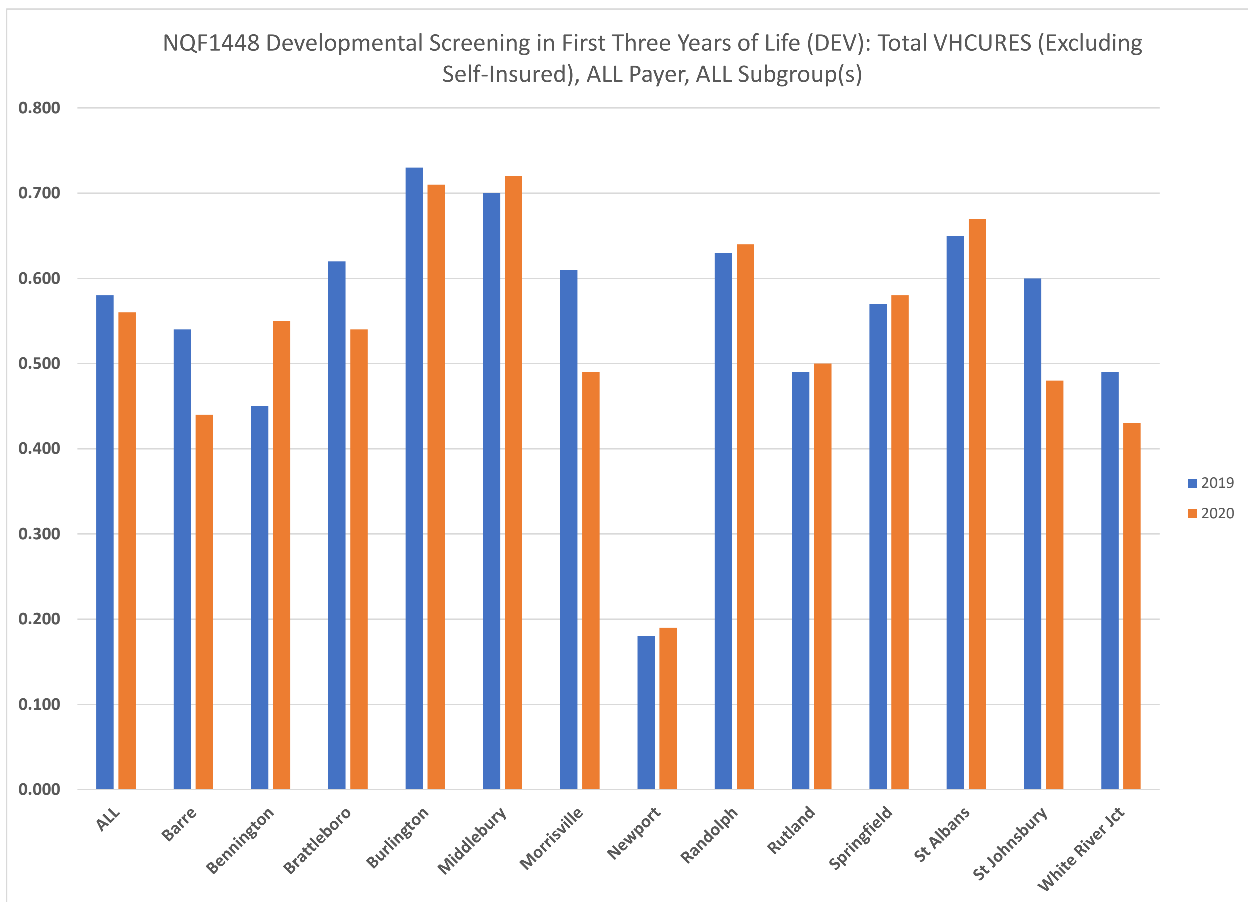


Access-To-Care and Healthcare Utilization Measures

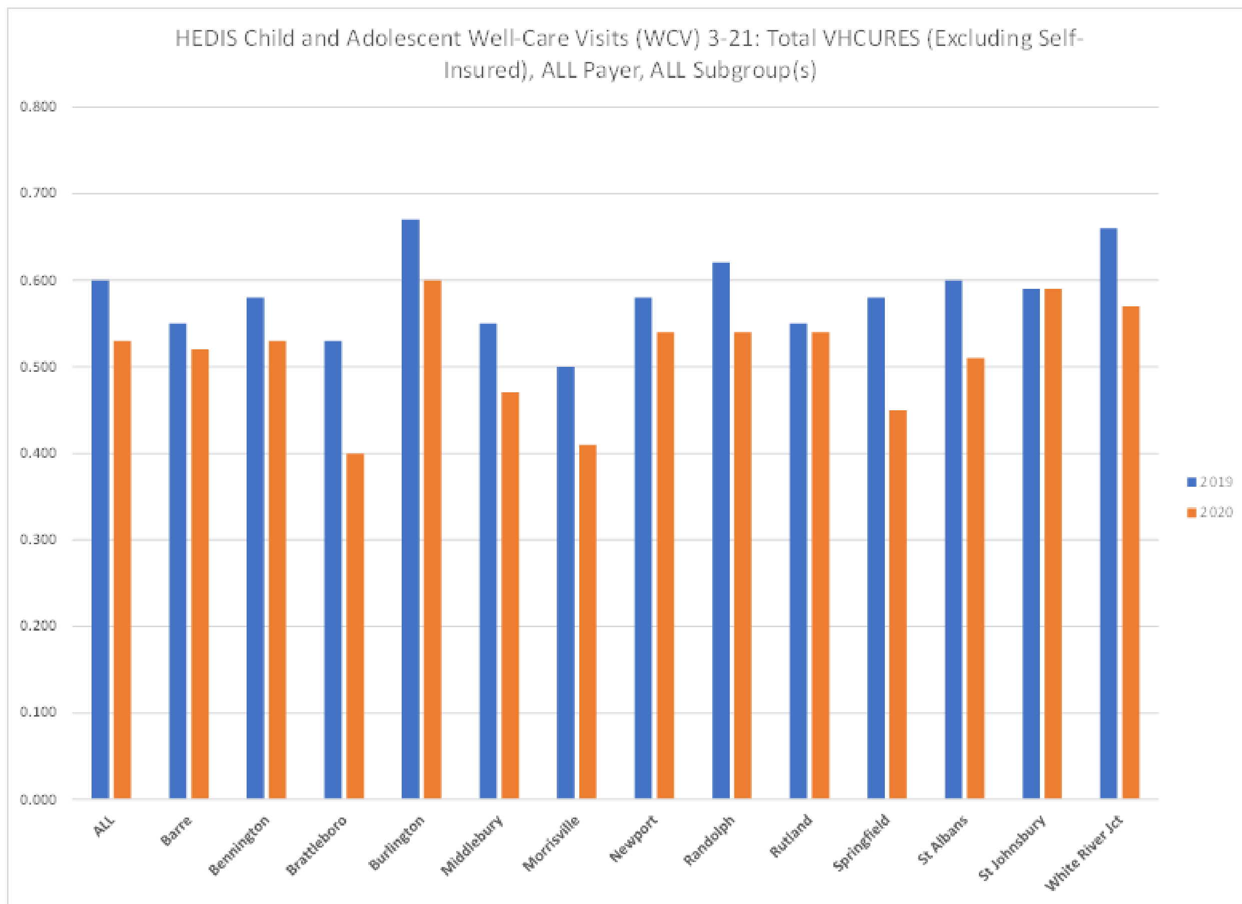
As stated above, 68.8% of VHCURES members who received primary care services were served by PCMHs in CY 2020. 92.0% of VHCURES members had a primary care visit during CY 2020, which was a decrease from 93.0% in CY 2019.

NQF1448 Developmental Screening in the First Three Years of Life (DEV), Non-Risk-Adjusted (Proportions):

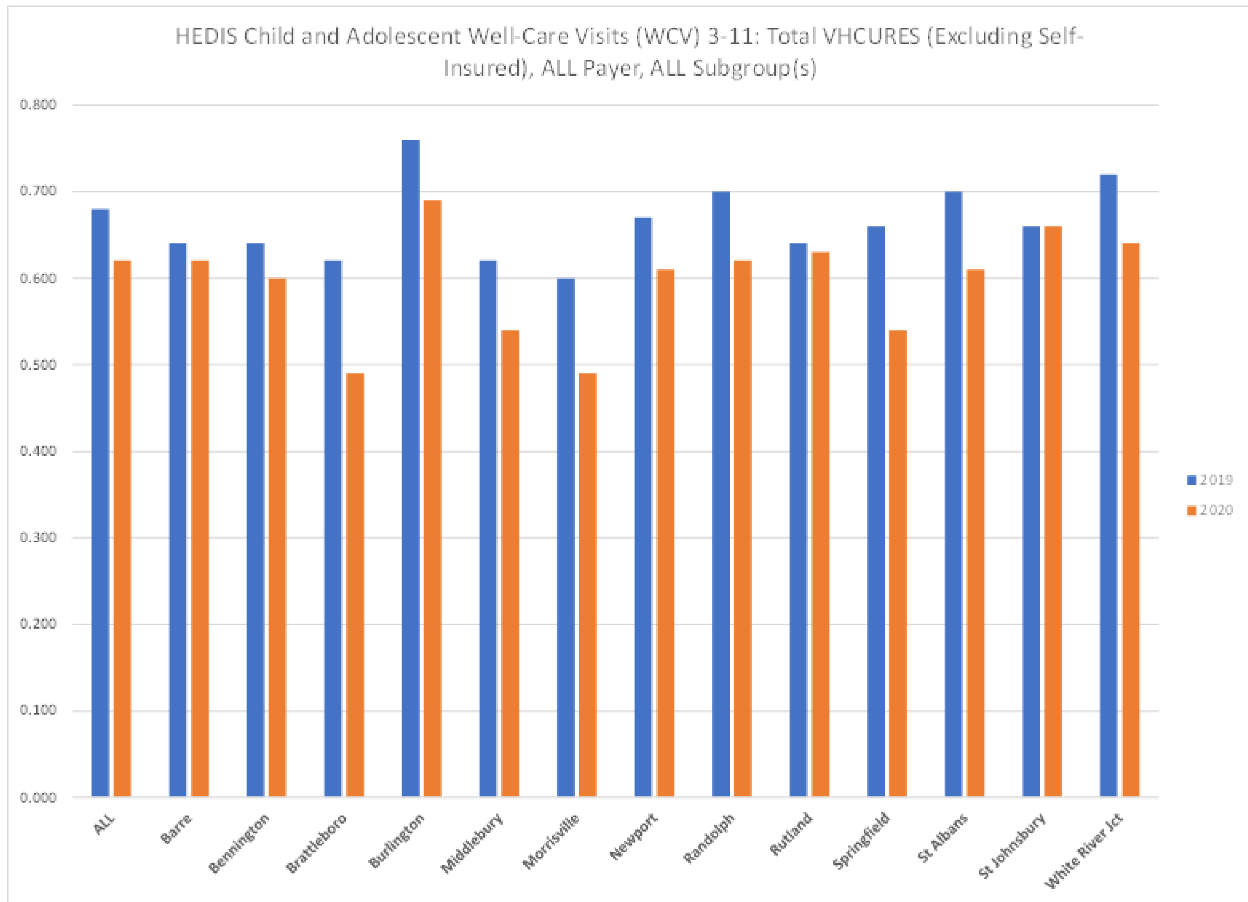
Total VHCURES (Excluding Self-Insured) Population



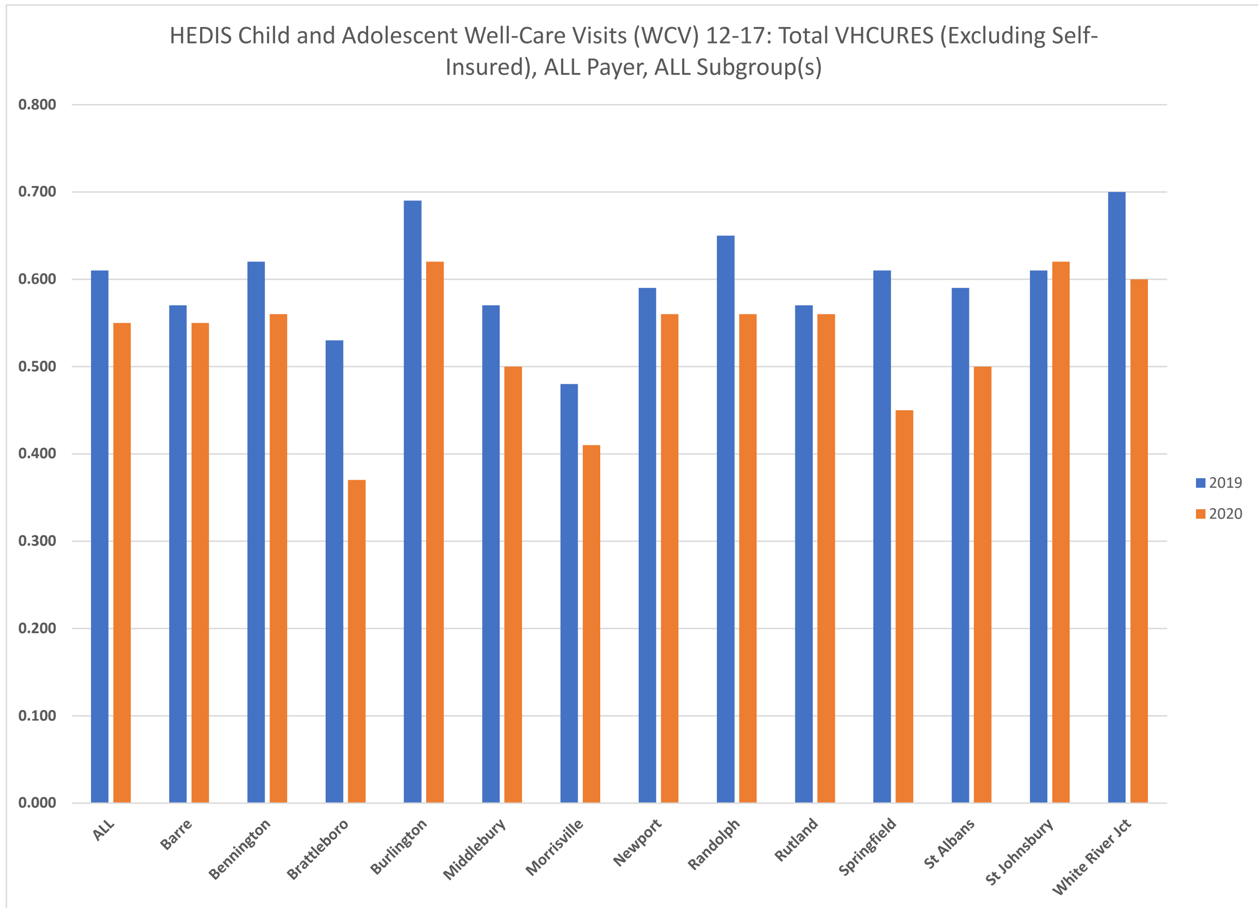
HEDIS Child and Adolescent Well-Care Visits (WCV) 3-21: Total VHCURES (Excluding Self-Insured) Population



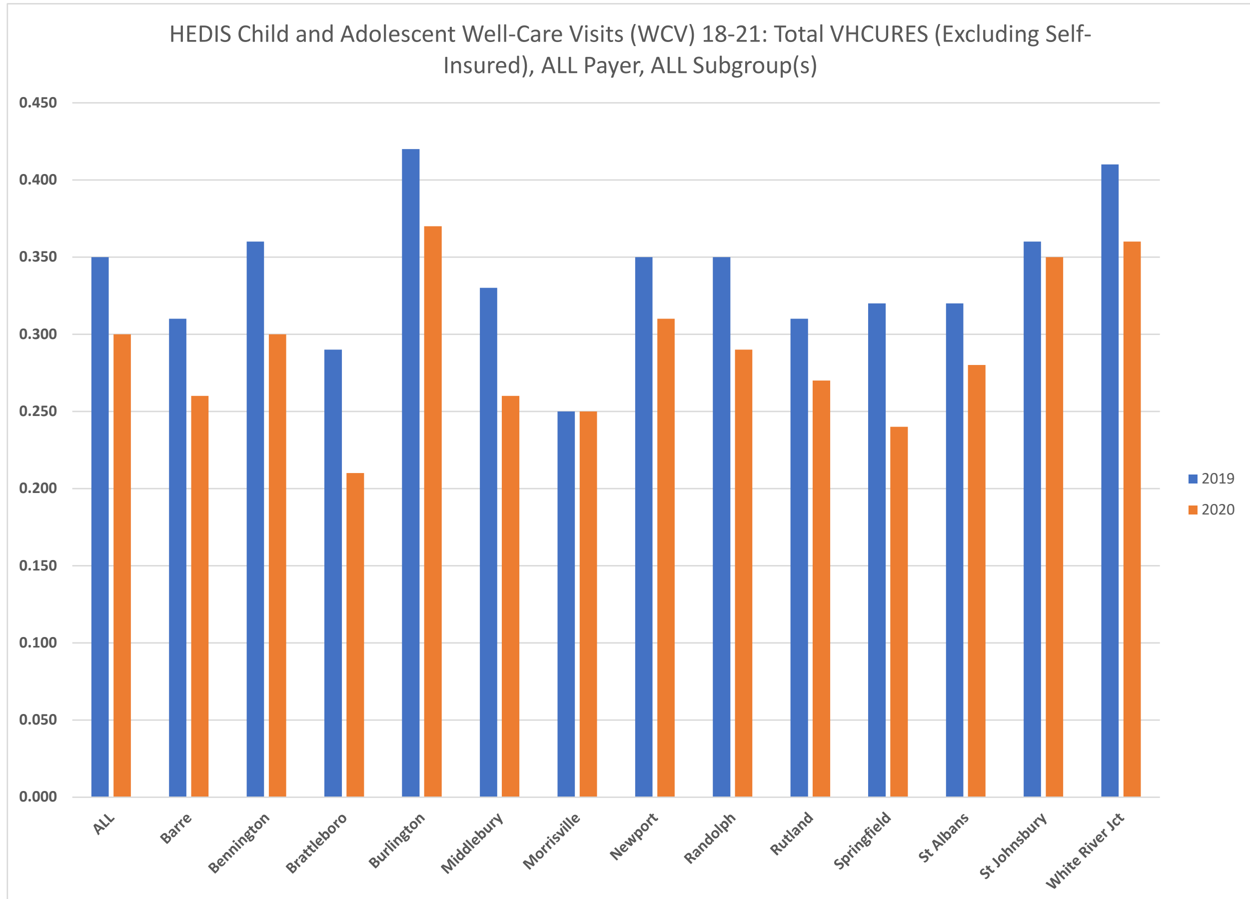
HEDIS Child and Adolescent Well-Care Visits (WCV) 3-11: Total VHCURES (Excluding Self-Insured) Population



HEDIS Child and Adolescent Well-Care Visits (WCV) 12-17: Total VHCURES (Excluding Self-Insured) Population

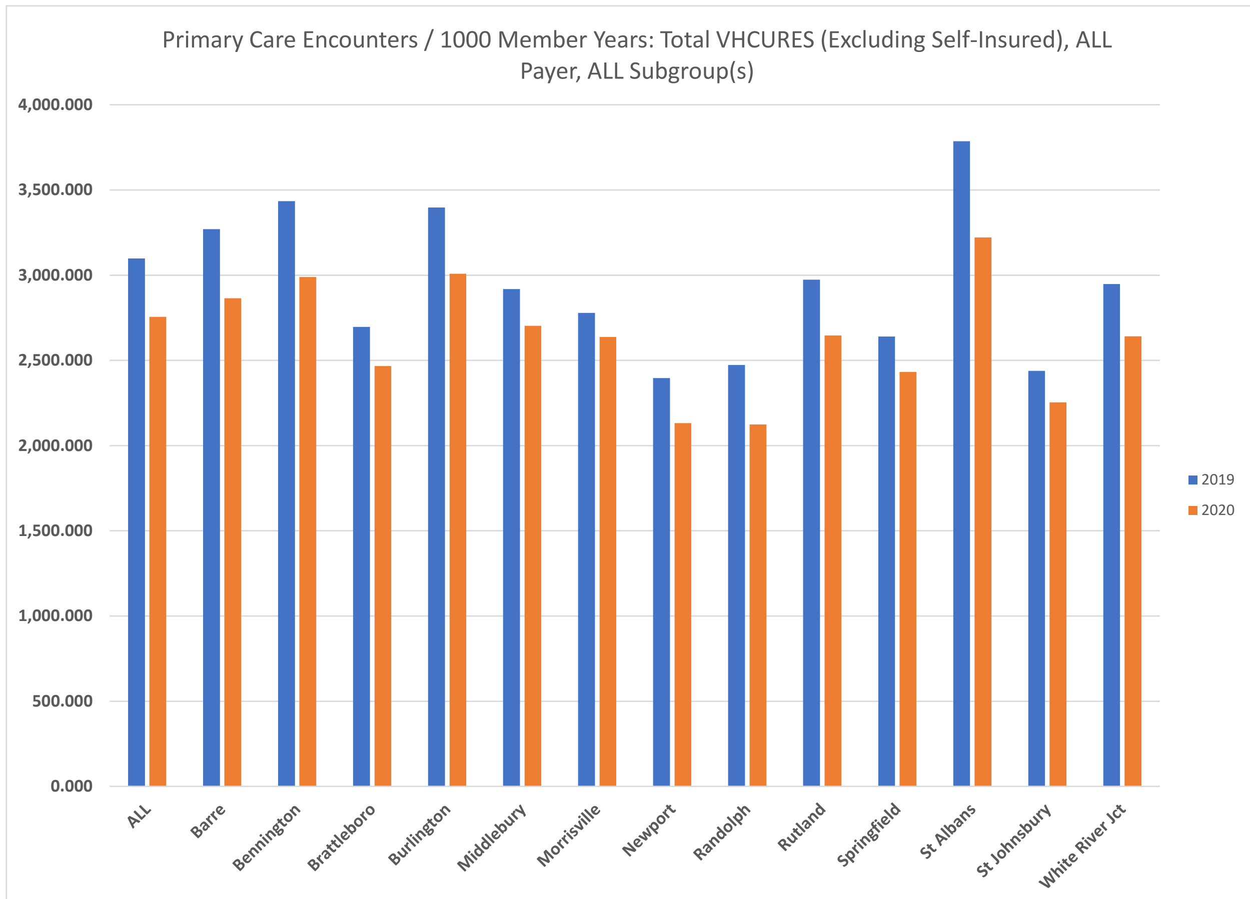


HEDIS CHILD and Adolescent Well-Care Visits (WCV) 18-21: Total VHCURES (Excluding Self-Insured) Population



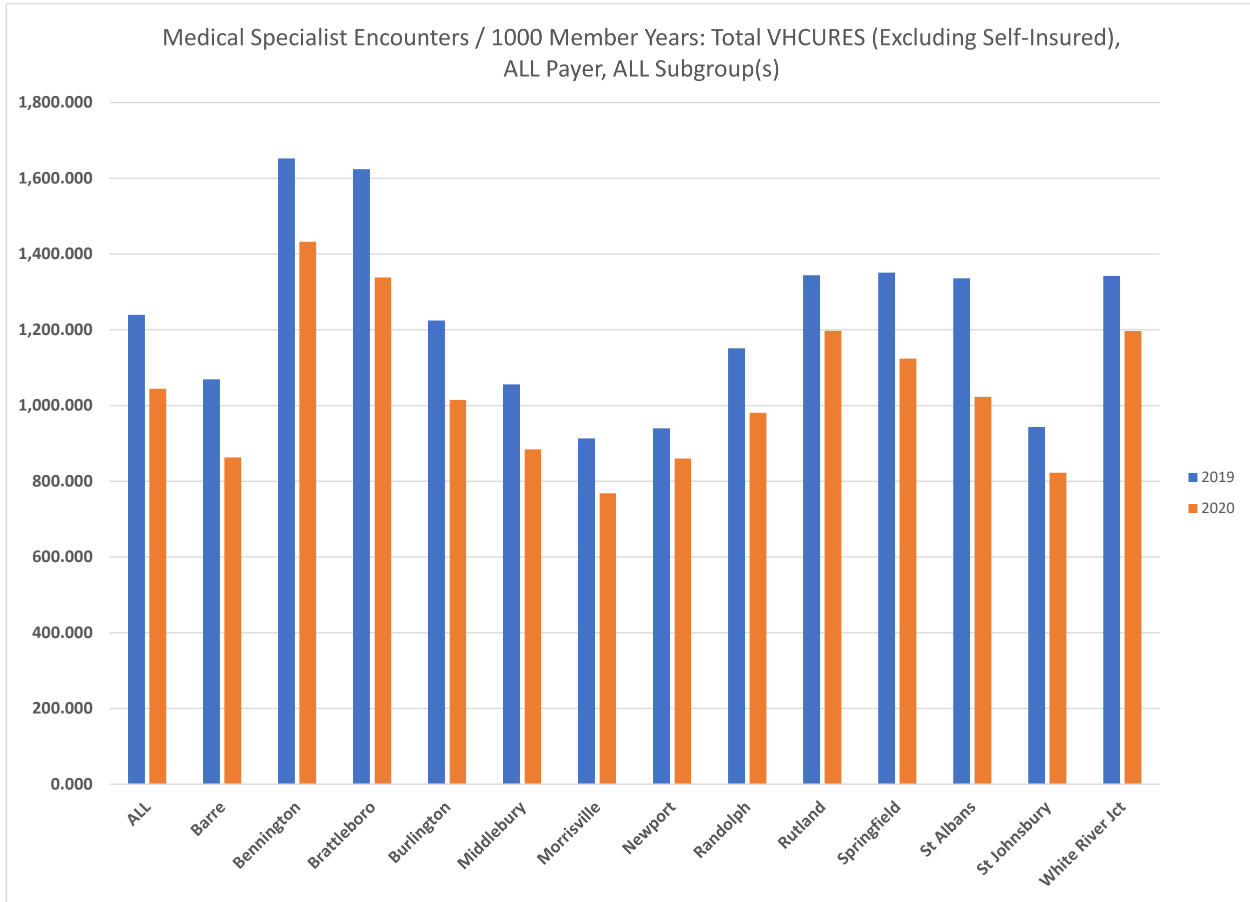
Primary Care Encounters / 1000 Member Years:

Total VHCURES (Excluding Self-Insured) Population



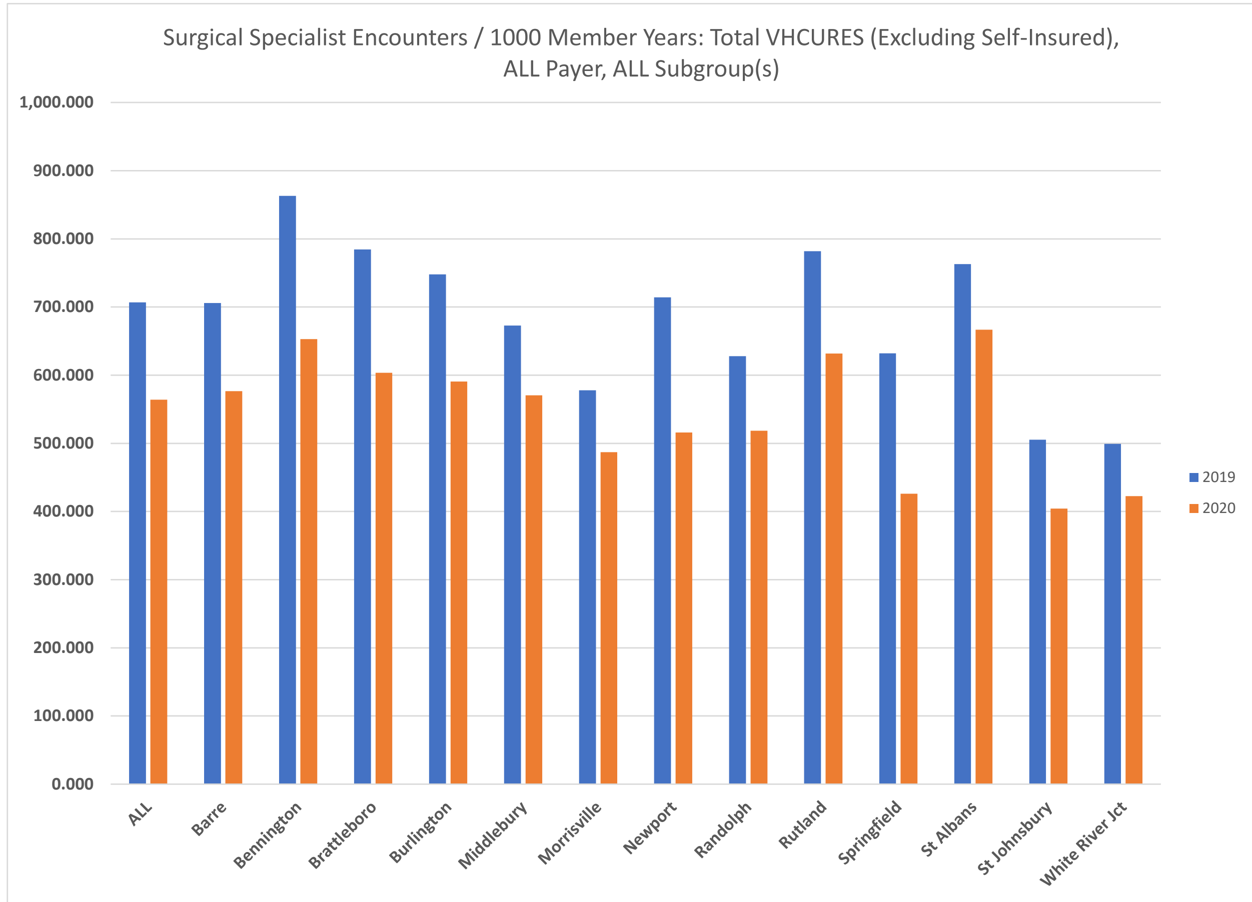
Medical Specialist Encounters / 1000 Member Years:

Total VHCURES (Excluding Self-Insured) Population



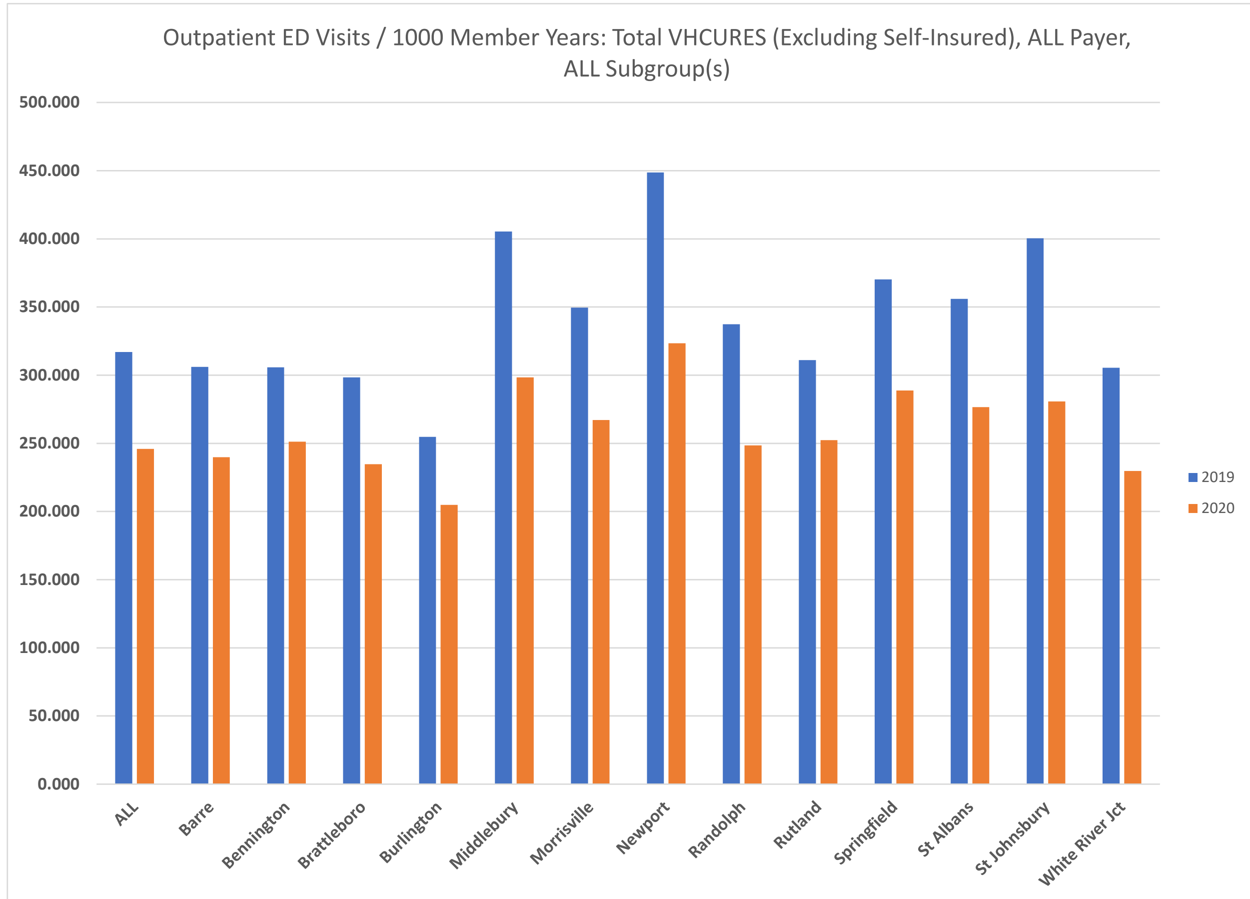
Surgical Specialist Encounters / 1000 Member Years:

Total VHCURES (Excluding Self-Insured) Population



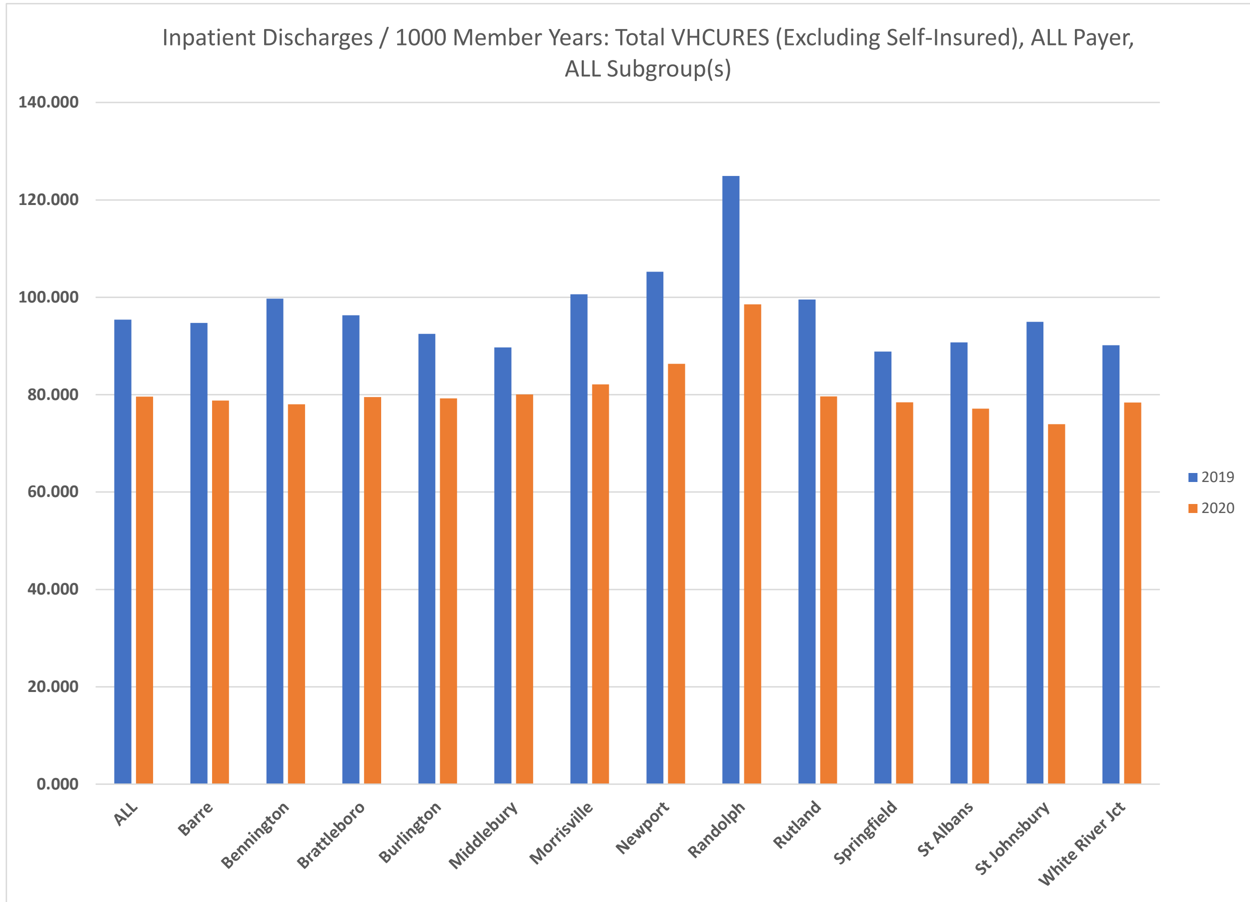
Outpatient Emergency Department Visits / 1000 Member Years:

Total VHCURES (Excluding Self-Insured) Population



Inpatient Discharges / 1000 Member Years:

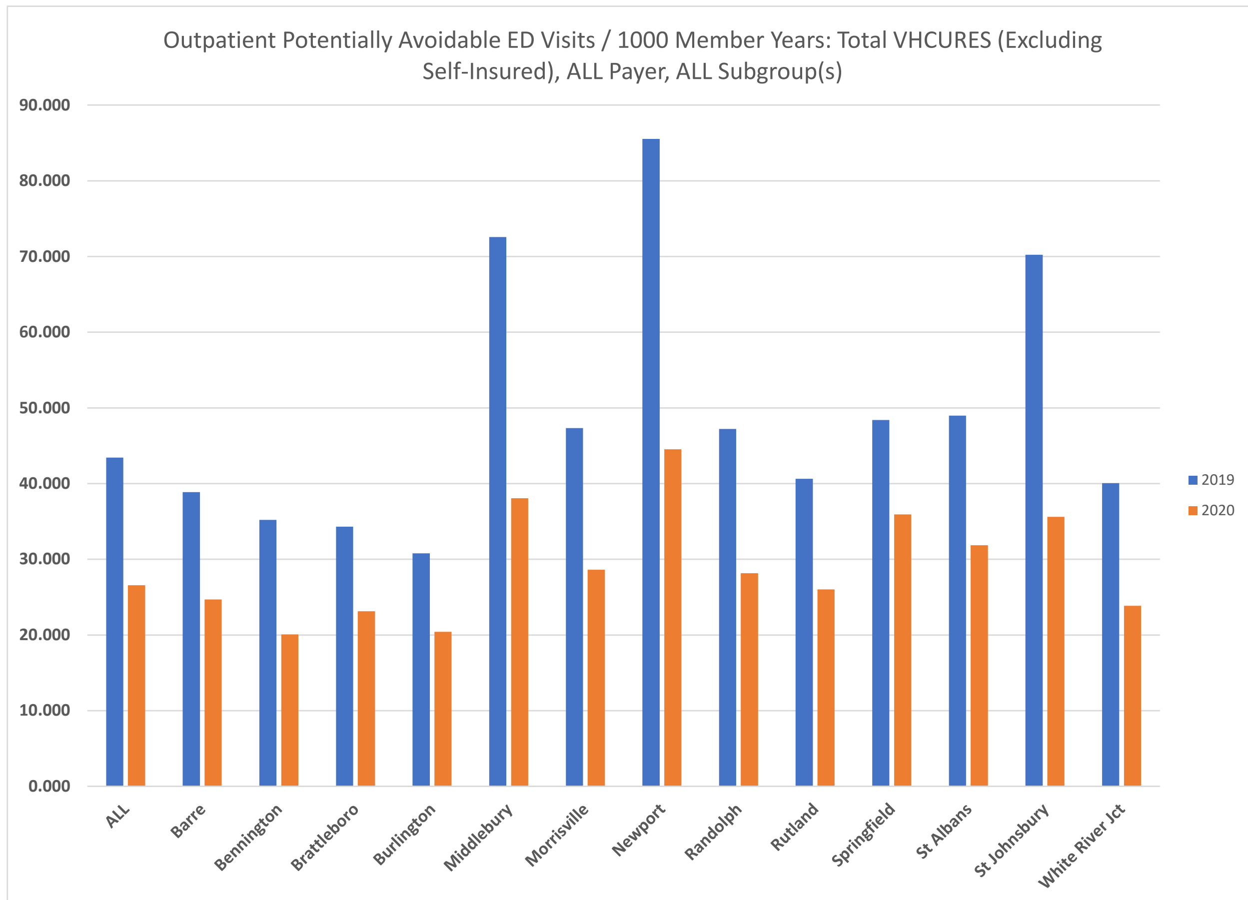
Total VHCURES (Excluding Self-Insured) Population



Measures of Potentially Low-Value Healthcare Utilization

Outpatient Potentially Avoidable Emergency Department Visits / 1000 Member Years:

Total VHCURES (Excluding Self-Insured) Population



PQI92 Chronic Composite - Ambulatory Care Sensitive Condition Inpatient Discharges / 1000 Member Years:

Total VHCURES (Excluding Self-Insured) Population