Report to

The Vermont Legislature

Annual Report on the Vermont Blueprint for Health

In Accordance with 18 V.S.A. § 709

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

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Commissioner

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VERMONT

AGENCY OF HUMAN SERVICES
DEPARTMENT OF VERMONT HEALTH ACCESS

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Legislation & Report Contents

18 V.S.A. § 709. requires the Blueprint for Health (Blueprint) to make an annual report to the Vermont 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 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] bolstered by multi-disciplinary Community Health Teams (CHTs) supporting 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 and specialty care practices providing medication-assisted treatment (MAT). The Blueprint also created the Women's Health Initiative to ensure more choice and access to services that support pregnancy intention.

The Blueprint is a demonstrated leader in establishing a statewide network of PCMHs supported by CHTs focused on integrating care and services. Ahead of its time when piloted in 2008, the Blueprint's payment reforms fall into Category 4a of the CMS Health Care Payment Learning and Action Network framework for moving away from fee-for-service reimbursement.[3] The Blueprint model adds a per member per month payment for coordinating primary care services and improving quality and value performance on top of existing fee-for service payments. Building on the Blueprint's foundation, Vermont's All-Payer Accountable Care Organization

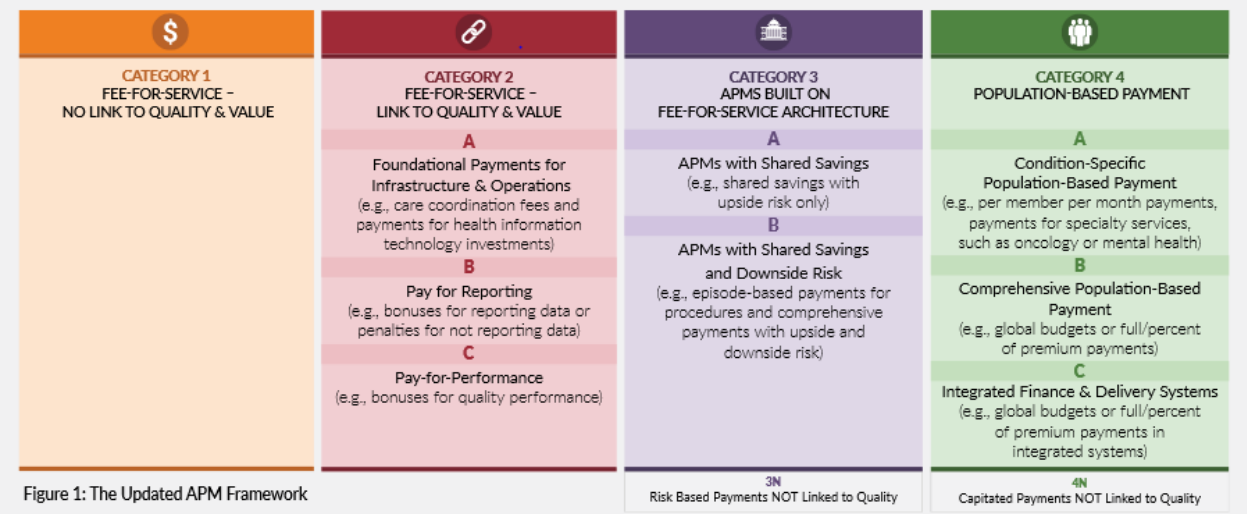
[1] The National Committee on Quality Assurance (NCQA) sets standards around the following elements of the PCMH model: 1) team-based care; 2) understanding and managing patient needs; 3) patient-centered access and continuity; 4) care management protocols; 5) care coordination and transition protocols; 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.

[3] Centers for Medicare and Medicaid Services, Health Care Payment Learning and Action Network (2020). Retrieved from https://innovation.cms.gov/innovation-models/health-care-payment-learning-and-action-network

(ACO) Model advances additional payment and delivery system reform initiatives into Categories 4B and C to move the State more aggressively away from fee-for-service. The Blueprint has aligned with OneCare Vermont, a statewide ACO, in a coordinated care delivery model and is poised to push the envelope on care and service delivery integration across a broader continuum of services, including housing supports and correctional services for example. To accelerate the Blueprint's complementary function with Vermont's All-Payer ACO Model Agreement, the Blueprint for Health has been re-located within the Office of Health Reform in the Secretary's Office at the Agency of Human Services where it joins the Health Information Exchange initiative and can be ideally coordinated with the Agency of Human Services' field teams and Vermont Chronic Care Initiative.

Figure 1: The Updated APM Framework



This implementation status report on the Blueprint is structured into 5 sections: 1) an overview of the Blueprint's role in facilitating community-led transformation; 2) health care service reforms and operations supported by the Blueprint; 3) efforts related to the state's COVID-19 response; 4) the program's analytic and evaluation efforts; and 5) an in-depth look at activities at the local level in the Health Service Areas (HSAs) At-a-Glance section.

1) Community-Based Facilitation of Health Reform

The network of staff in each of the HSAs, namely Program Managers, Quality Improvement Facilitators, and Community Health Team Leaders have a critical role in the health care reforms that have been supported through the Blueprint. They contribute to identifying the concerns and challenges at the local level and provide feedback to inform the broader evidence-based strategy to address common challenges. They also work with local leaders in co-designing implementation strategies, so reforms work for that specific community. Finally, they have an important role in connecting regional social and health care services for improved coordination and integration at a local level. The work of these networks is supported by the Blueprint's central office staff, including analytic and reporting services, and by grants and contracts that flow through the Administrative Entity in each HSA. Funding for the regional networks is primarily supported through Vermont's Global Commitment to Health 1115 Medicaid waiver, with supplemental funding from regional health care organizations.

2) Blueprint for Health Services

The Blueprint services began with the original primary care PCMH and CHT services. Currently

134 primary care practices, including hospital-owned practices, independently owned practices, and Federally Qualified Health Centers (FQHCs), participate in the Blueprint. Annually, they must meet national standards for quality and care coordination as set by the National Committee for Quality Assurance (NCQA). The all-payer support for CHTs results in staff and services in practices and communities. The 168 full time equivalent (FTE) staff includes nurses, care coordinators, social workers, and health coaches. This anchoring workforce for care coordination is foundational to implementation of the ACO care model. Funding to support PCMH activity and CHT services is made possible through multi-payer participation in the program.

Additionally, the Blueprint includes funding for Self-Management workshops for people living with chronic conditions who want to learn and practice strategies and techniques to manage their conditions and improve wellbeing.

The Hub & Spoke system of care has significantly expanded access to treatment for opioid use disorder with an additional 70 FTE staff of nurses and counselors integrating mental health and addictions care into general medical and specialty practices, and by increasing the collaboration between Hubs and Spokes in care coordination.

The workflow and payment reforms of the Women's Health Initiative (WHI) bring social determinants of health screening and same day access to family planning services into Ob-Gyn and family medicine practices. The 11.5 FTE WHI social workers act to both integrate interdisciplinary health services into Ob-Gyn specialist practices and to coordinate needed physical health, mental health, and social services on behalf of reproductive age women.

Each of the services were developed with the goal to achieve better coordinated and integrated care.

3) Response to COVID-19 Pandemic

The year 2020 was one of unprecedented challenge. Beginning in March when Governor Phil Scott declared a state of emergency in Vermont, to the present, Blueprint Program Managers, CHTs, PCMHs, specialty practices, and Spokes have acted quickly to provide continuity of care. The local Blueprint responses to the Covid-19 pandemic demonstrated the value of local networks supported with alternative payments. While the Blueprint Program Managers and CHTs have always been an integral part of their communities, the COVID-19 pandemic demonstrated how important this integrated community-based healthcare coordination is in times of crisis.

4) Blueprint Data and Analytics

The program's data and analytic services serve two roles. The first is to provide operational data needed to work with payers on setting payments monitoring the different Blueprint initiatives. The second has involved providing all-payer, whole population reporting that can be used for quality improvement and program evaluation at the practice, community, and state levels. The Blueprint relies on administrative and clinical data collected during the normal course of service provision and rarely asks primary care practices or other service providers for additional information. The use of surveys is restricted to the patient experience of care survey conducted annually. The Blueprint team and analytic contractors link claims, clinical, and other data sets for more holistic understanding of service costs, utilization patterns, and outcomes.

5) Health Service Areas (HSAs) At-a-Glance

This section highlights the work of the Blueprint facilitation infrastructure community-by-community. It shares information about what practices participate in the program and the number of FTE staff supported via the Blueprint services. It also provides a community perspective on local achievements and activities.

Conclusion

The Blueprint for Health has supported health care reform from its earliest focus as a chronic care initiative to its current form as a program supporting strong primary care and coordination of medical and social services across communities. The regional leaders comprising Blueprint's network have key roles in facilitating local change and innovation while promoting national standards of care, contributing to the long-term success of the program. The Blueprint has also evolved with the changing landscape of health care reform. As the state continues to work to achieve its health care reform targets for cost containment and access to and quality of care, the health care elements established and supported by the Blueprint provide the necessary foundation for future efforts in health care reform, including the coordination of services provided by primary care, hospitals, medical specialists, and community-based organizations as envisioned in the Vermont All-Payer ACO Model Agreement.

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[4] 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[5].

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 more choice and 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 and is based around five key elements: 1) goal identification 2) service delivery reforms such as advanced primary care, Community Heath Teams, self-management programs, the Hub and Spoke system of care, and the Women's Health Initiative; 3) multi-payer supported payment reform via per member per month payments and other value-based payments; 4) support for facilitating local transformations; and 5) analytics and evaluation.

The Blueprint is a demonstrated leader in establishing a statewide network of PCMHs supported by CHTs focused on integrating care and services. Ahead of its time when piloted in 2008, the Blueprint's payment reforms fall into Category 4a of the CMS Health Care Payment Learning and Action Network framework for moving away from fee-for-service reimbursement.[6] The Blueprint model adds a per member per month payment for coordinating primary care services and improving quality and value performance on top of existing fee-for service payments. Building on the Blueprint's foundation, Vermont's All-Payer Accountable Care Organization (ACO) Model advances additional payment and delivery system reform initiatives into Categories 4B and C to move the state more aggressively away from fee-for-service. The Blueprint has aligned with OneCare Vermont, the statewide ACO, in a coordinated care delivery model and is poised to push the envelope on care and service delivery integration across a broader continuum of services, including housing supports and correctional services for example. To accelerate the Blueprint's complementary function with Vermont's All-Payer ACO Model Agreement, the Blueprint for Health has been re-located within the Office of Health

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[6] Centers for Medicare and Medicaid Services, Health Care Payment Learning and Action Network (2020). Retrieved from https://innovation.cms.gov/innovation-models/health-care-payment-learning-and-action-network

Reform in the Secretary's Office at the Agency of Human Services where it joins the Health Information Exchange initiative and can be ideally coordinated with the Agency of Human Services' field teams and Vermont Chronic Care Initiative.

Figure 2: The Updated APM Framework

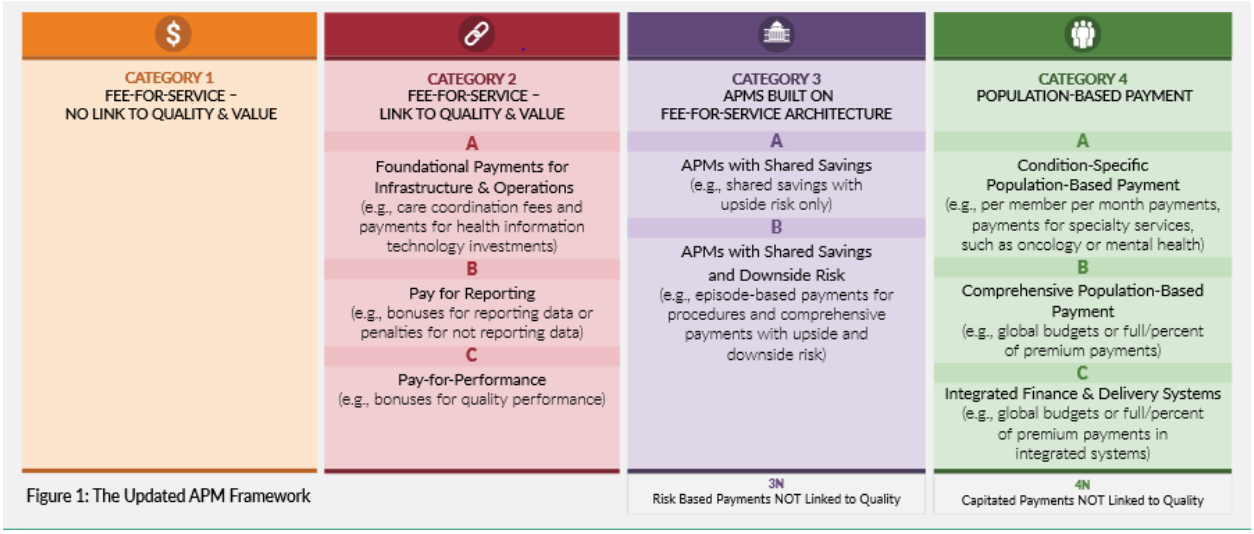


Figure 1: The Updated APM Framework

This implementation status report will provide an update on the Blueprint for Health operations and accomplishments in 2020, which was a year of extraordinary challenge and change; it will also provide a detailed description of the program's elements and how they fit into the evolving state of health care reform. It will do so in 5 sections: 1) an overview of the Blueprint's role in facilitating community-led transformation; 2) health care service reforms and operations supported by the Blueprint; 3) efforts related to the state's COVID-19 response; 4) the program's analytic and evaluation work; and 5) an in-depth look at activities at the local level in the HSAs At-A-Glance section.

Community-Based Facilitation of Health Reform

This section focuses on support the Blueprint has provided to practices and communities to facilitate the implementation of health care reforms, such as gaining recognition as PCMHs, improving communication and coordination across health and social services in a community, and using data to address quality improvement initiatives. The approach to reform that the Blueprint has taken incorporates changes in service delivery, changes in how payments are made - ideally aligned across payers, and support for providers and communities in implementing these changes. This last element, which incorporates a process of co-design with local health systems has proven highly effective in enduring reforms.

Figure 3: Process of Approaching Reform for Blueprint Programs

The network of local health reform leaders, which includes Blueprint Program Managers, Quality Improvement Facilitators, and Community Health Team Leaders, is one element that has differentiated the Blueprint's approach from other health care reform efforts. This network is essential to the Blueprint's objective of continuously strengthening local health systems to provide care coordination, advance population health goals, and manage cost risks arising from shifts to value-based payments. For example, the network supports all participating practices in the community as well as the CHTs in efforts such as initiating and sustaining workflow changes, quality improvement efforts, and connections across community networks. This approach has allowed the Blueprint to move beyond "care management" and focus on the *integration* of physical health care, social services, mental health care, and substance use disorder treatment services to meet the holistic needs of all Vermonters.

The positions in this network are supported through the Blueprint's Global Commitment to Health[7]-funded grants made to the local Administrative Entities, which are either the local hospital or FQHC. In addition to funding this network, the Blueprint provides participants with oversight, coaching, educational offerings, and peer-to-peer learning opportunities. This system of Program Managers, Quality Improvement Facilitators, and Community Health Team leaders is the foundation upon which other evolving health reforms are built, with payments to local systems resulting in staffing on the ground to accomplish reform goals.

Administrative Entities

The Blueprint has established a single Administrative Entity in each of the 13 Health Service Areas (HSAs) at either the local hospital or Federally Qualified Health Center (FQHC). Through these entities flow Blueprint funding, such as Blueprint grants and CHT payments, and state-level strategic directions for implementing health care initiatives at the local level. Specifically, their work includes local program leadership, financial management, and staffing of CHTs. The Administrative Entities also hire the Program Managers, who lead implementation and engage

[7] Vermont Agency of Human Services. (2020). *Global Commitment to Health 1115 Waiver*. Retrieved from https://humanservices.vermont.gov/about-us/medicaid-administration/global-commitment-health-1115-waiver

community partners[8] at the local level. These same Administrative Entities are all ACO participants, so these leaders work on behalf of both the Blueprint and the ACO. Furthermore, each Administrative Entity contributes their own financial and human resources, beyond the scope of their Blueprint grants, demonstrating their commitment to primary care and improved population health. In turn, the Blueprint's grants help support local systems of care.

Blueprint Program Managers

Blueprint Program Managers provide leadership in each community to coordinate healthcare delivery system improvement efforts. While they are employed by the hospital or FQHC in the HSA, they help organize, lead, and staff collaborative initiatives with the ACO, local human service agencies, health departments, specialty care providers, mental health providers, and primary care providers to facilitate the integration of services. They are responsible for contacting all primary care practices within their HSA to encourage, engage, and support practice participation in the Blueprint and other health system reform activities. Additionally, Program Managers are responsible for administering funds and staffing plans for the local CHTs on behalf of all participating payers, including core CHT, Spoke staff, and WHI staff. Program Managers set up the systems through which integrated services can be delivered in the community.

> *"Consistent Blueprint funding during the pandemic allowed the team to continue to provide care coordination and check in with people telephonically. We used data to do targeted outreach to people who we were concerned about because of isolation, including the elderly and people who did not have an affordable way to get medication. People with food insecurity, those losing jobs, or people underemployed. We contacted people that had never been eligible for Medicaid but couldn't afford health insurance and were now eligible." -**Lamoille County HSA Blueprint PM***

Blueprint Quality Improvement Facilitators

In addition to Program Managers, the Blueprint supports participating practices with a quality improvement coach, called a Quality Improvement (QI) Facilitator. QI Facilitators support practices with Blueprint-generated all-payer data on practice performance and their own training and expertise in process improvement methodologies (such as Clinical Microsystems, Model for Improvement, and Lean process improvement). Quality Improvement Facilitators initially help primary care practices to secure NCQA PCMH recognition.[9] After recognition is achieved, the facilitators regularly return to help with quality improvement efforts related to panel management and outreach, care coordination, promotion of individual health and wellness, chronic condition management, and ongoing practice transformation in alignment with State-led health care reform priorities. These priorities include:

- focusing quality improvement activities on All-Payer ACO Model[10] and ACO quality measures
- promoting team-based care
- implementation of Blueprint and other health care reform initiatives (e.g., Spoke program, Women's Health Initiative, improving opioid prescribing patterns)

[8] 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.

[9] National Committee for Quality Assurance. (2020). Retrieved from https://www.ncqa.org/programs/health-care-providers-practices/patient-centered-medical-home-pcmh/

[10] Green Mountain Care Board, Vermont's All-Payer Model. (2020). Retrieved from https://gmcboard.vermont.gov/payment-reform/APM

- prevention and management of chronic conditions (e.g., for diabetes and hypertension through connections with learning collaboratives, self-management programs, health coaches, registered dieticians, and care management).

A summary of the Blueprint program elements (services and facilitation supports) and budget is shown in Table 1 below.

Table 1: Blueprint for Health Annual Budget by Program Elements and Funding Source

Blueprint Program Elements	Annualized Budget for 2020	Description	Money Flow	Payer Participation
Patient-Centered Medical Home (PCMH) Program				
PCMH Per Member Per Month (PMPM) Payments	$9,821,223	PMPM Quality Payments for NCQA Recognition	From Payers to Practices (Parent Organizations)	All Payers
QI Facilitators	$1,016,840	In practice QI coaching for NCQA, ACO priorities, and practice priorities	Grant to Local Hospital or Contract w/ QI facilitator	DVHA / Medicaid
Community Self-Management Program				
Regional Coordinators	$427,050	Part time staff to organize workshops	Grant to Local Hospital	DVHA / Medicaid
Master Trainers	$25,000	Train workshop leaders	Grant to Local Hospital	DVHA / Medicaid
Workshop Costs	$210,750	Leader stipends, materials, rooms	Grant to Local Hospital	DVHA / Medicaid
Management Contract	$199,000	Data aggregation, leader training	Contract with Local Hospital	DVHA / Medicaid
Community Health Teams (Core/Primary Care)	$9,381,138	Teams support PCMH practice and interface with community services	From Payers to Local Hospital	All Payers
Spoke Staff (Extended CHT)*	$6,607,313	RN & Counselor teams support MAT prescribers	From Payer to Local Hospital	DVHA / Medicaid
Women's Health Initiative				
PMPM Payment to Specialty Practices	$171,561	Attestation to program elements	From Payer to Practices	DVHA / Medicaid
PMPM Payment to PCMH Practices	$79,320			
One-Time Practice Payments	$31,926	Workflow changes for screening, same-day long-acting reversable contraception	From Payer to Practices	DVHA / Medicaid
Social Workers (Extended CHT)	$1,011,249	Staff for brief interventions and navigation to services	From Payer to Local Hospitals	DVHA / Medicaid
Program Management	$1,207,000	Change management & program administration	Grant to Local Hospital	DVHA / Medicaid
Data and Analytics Contracts				
All-Payer Analytics †	$340,600	Program evaluation & payment	Contract with Vendor	DVHA / Medicaid
Medicaid Analytics†	$300,000	Federal reporting and evaluation	Contract with Vendor	DVHA/Medicaid
Patient Experience of Care Survey	$136,000	Survey of Vermonters served in primary care in accordance with statute	Contract with Vendor	DVHA / Medicaid

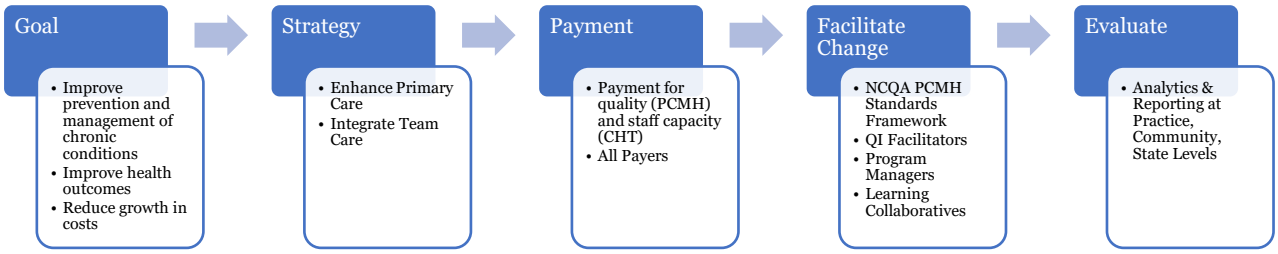
* Vermont Department of Health manages Hubs

† Represents a significant decrease in funding from 2019 and much was not expended in 2020 due to a disruption in analytic contraction. Amounts are currently allocated for 2021

Blueprint for Health Services

Patient-Centered Medical Home Program

Figure 4: Primary Care Reforms



The original development of the Blueprint program was based on the observation that effective health systems have strong, well-funded, primary care services. The program was first authorized as a pilot in 2008 and as a statewide program in 2010 by the Legislature to support the transformation of primary care services in Vermont as a foundational first step in health system reform. While the Blueprint program highly values local innovation, as mentioned above, it also equally weights the use of national standards to drive improvements in primary care delivery, quality, and payment. To this end, the State of Vermont uses NCQA standards for recognizing Patient-Centered Medical Homes (PCMH). The PCMH model supports care that is patient-centered, team-based, comprehensive, coordinated, accessible, and focused on quality and safety. The model also promotes care that is provided when and where the patient needs it, and in a way that the patient understands. Additionally, these standards require that measures be based on the practice's entire patient panel, not only those patients attributed to an ACO or to any single payer.

Almost all of Vermont's primary care practices participate in the Blueprint program, and these 134 PCMHs currently serve 302,548 insurer-attributed patients. Attribution to a practice is determined by the practice at which the patient has received most of their primary care within the 24 months prior to the date the attribution process is conducted. Payers, including Medicare, Medicaid, and major commercial payers in Vermont, make per member per month (PMPM) payments directly to practices based on the number of the payer's patients attributed to each practice. In 2020, the 134 primary care practices (or their parent organizations) collectively received an estimated $11,233,915 in PCMH payments.

2020 Program Updates

In response to the COVID-19 pandemic and recognizing the difficulties practices experienced during the early days of the pandemic, the Blueprint worked with NCQA to extend the Annual Reporting deadlines between March and December 2020, which maintained their PCMH status during this period. The adjusted deadlines now reflect an Annual Reporting date of December 1, 2020, and a recognition end date of December 31, 2020.

Community Health Teams

PCMHs in Vermont are supported by Community Health Teams (CHTs), which are multi-disciplinary teams of dedicated health professionals in each of the state's HSAs. These teams provide supplemental services that allow Blueprint-participating primary care practices to focus on promoting prevention, wellness, and coordinated care. The CHTs support primary care providers in identifying root causes of health problems, including screening for mental health needs, substance use disorders, and social determinants of health (SDOH). They also connect patients with effective interventions, manage chronic conditions, and provide additional

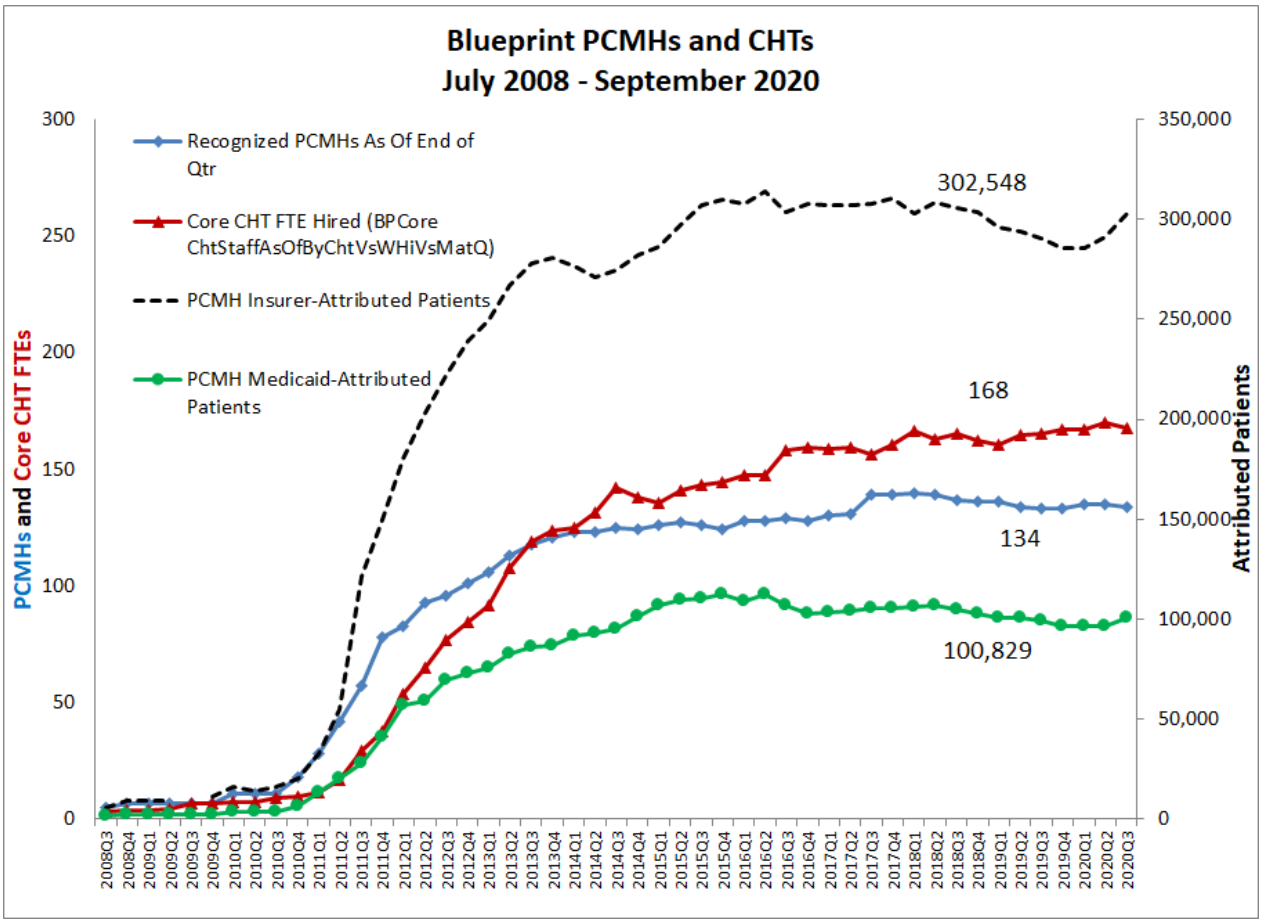
opportunities to support improved well-being. Across the 13 HSAs, 168 FTE CHT staff members support PCMHs. Payers fund the CHT staffing through PMPM payments made directly to the Administrative Entities based on data provided by the Blueprint. 'Core' CHT services include:

- population/panel management and outreach
- individual care coordination
- brief counseling and referral to more intensive mental health care as needed
- substance use treatment support
- condition-specific wellness education, and more

The services may be co-located with the practices (also known as 'embedded') or centralized in the HSA and shared across multiple practices. Actual service configuration, staffing, and location are determined by local leaders based on community demographics and health needs, identified gaps in available services, and the strengths of local partners. Funded by Medicaid, Medicare, and major commercial insurers, access to local CHTs is offered barrier-free to patients and practices (meaning no co-payments, no prior authorizations, and no billing). Further, these services are available regardless of whether the individual is attributed to the ACO. Vermont's payers (Medicaid, Medicare, BlueCross BlueShield of Vermont, MVP and Cigna) all make direct payments to the Administrative Entities to pay for the CHT staff. In 2020 these payments amounted to $9,381,138 to fund CHT staff capacity.

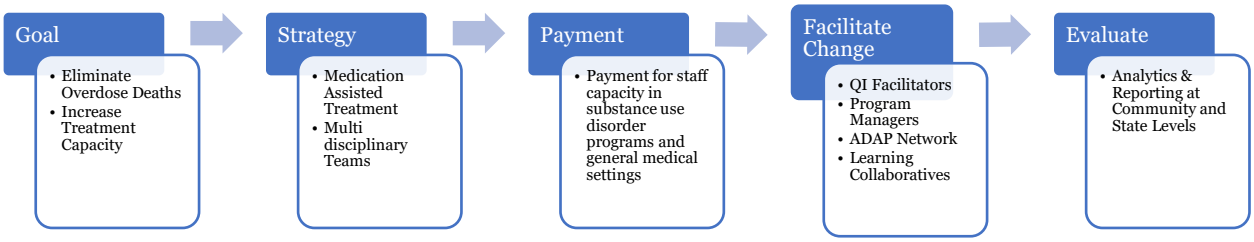
CHTs serve as the foundation for the ACO's care coordination activities on the ground. The majority of outpatient care coordinators in Vermont are Blueprint-funded CHT staff who manage care and services for ACO-attributed patients as well as those who are not attributed to the ACO. Multiple examples of this role are provided in the HSAs At-a-Glance section. The importance of the CHT in the ultimate success of the ACO model in Vermont makes the Blueprint program a critical partner in the All-Payer ACO Model implementation. The final section of this report, HSAs At-a-Glance, offers a portrait of the staffing and activities that are either directly funded or leveraged by the Blueprint payment and support services reforms.

Figure 5: PCMHs and CHTs by the Numbers



Hub & Spoke Program

Figure 6: Opioid Treatment Reforms



"Hub & Spoke" is Vermont's system of medication-assisted treatment (MAT), supporting people in recovery from opioid use disorder. Nine regional Hubs (or "opioid treatment programs") offer daily support for patients with complex addictions. At over 113 local Spoke practices (or "office-based opioid treatment"), doctors, nurses, and counselors offer ongoing opioid use disorder treatment fully integrated with general health care and wellness services. The Blueprint administers the Spoke part of the Hub & Spoke system.

Spokes are settings where opioid use disorder (OUD) treatment is integrated into general medical care, like treatment for other chronic diseases. These settings are mostly primary care or family medicine practices and may also include obstetrics and gynecology practices, specialty

outpatient addictions treatment programs, and practices specializing in chronic pain. Prescribers in Spoke practices are physicians, nurse practitioners, and physician assistants who are federally waivered to prescribe buprenorphine[11]. They may also provide oral naltrexone or injectable Vivitrol. Spokes receive specialized staff – one nurse and one licensed mental health/addictions counselor for every 100 Medicaid patients receiving medication-assisted treatment (MAT). Like the core CHT staff in primary care, the Spoke staffing helps expand access to treatment by supporting prescribers with multi-disciplinary teams to see patients more frequently, proactively monitor care, and coordinate patient care across health and human service systems. For patients, specialized Spoke staff are essential members of their care team; they work together towards long-term recovery and improved health and well-being. The Blueprint and the Vermont Department of Health's Division of Alcohol and Drug Abuse Programs (ADAP) offer ongoing training to Spoke prescribers and teams. More detail about the structure and impact of the Hub & Spoke System can be found on the Blueprint website.

2020 Program Updates

When the Hub & Spoke system of care launched in 2012, Spoke sites were serving approximately 2,500 patients. As seen in Figure 2 below, the overall MAT population has steadily increased in Vermont since the implementation of Hub & Spoke, resulting in approximately 6,000 Spoke patients receiving MAT treatment today. Figure 2 demonstrates the consistent growth and ongoing need, both of MAT and its wraparound Spoke services, within the Vermont population. Figure 3 below shows the growth of the Spoke program, including the number of providers, Spoke staff, and patients. The number of Medicaid beneficiaries receiving treatment in Spoke settings grew from 3,227 in the third quarter of 2019 to 3,744 in November 2020. As seen in Figure 3, 265 prescribers offered MAT in Spoke settings in November 2020, which is an increase from 260 in the third quarter of 2019. Of these prescribers, 83 treated ten or more individuals with opioid use disorder, an increase from 74 at the same time last year. Specialized Spoke staff, which include the nurses and license mental health professionals working with MAT patients in Spoke settings, included 70.9 FTE positions in November 2020.

VT Department of Health ADAP administers the Hub part of "Hub & Spoke." Hubs continue to report zero wait lists and the total caseload increased from 2019 with 3,751 patients seen in the second quarter of 2020. The number of Hub and Spoke patients from all payers is shown in Figure 2 below.

In 2020 the Blueprint helped expand access to treatment and improve quality of care for Vermonters with opioid use disorder through the following activities:

- The Blueprint contracted with Dartmouth College for the 2019-2020 MAT Learning Collaborative, which concluded in October 2020. This collaborative included five webinars, six training sessions, and one statewide conference. In response to the COVID-19 pandemic and Vermont's "Stay Home, Stay Safe" emergency declaration on March 13, 2020, Dartmouth College restructured the remainder of the Learning Collaborative to accommodate entirely virtual sessions. This involved a reworking of the curriculum for four of the six training workshops, as well as a shift of the statewide conference from one in-person event to a two-day virtual gathering.
- The Blueprint renewed its contract with Dartmouth College for the 2021 MAT Learning Collaborative. For January – June 2021, alternating didactic webinars and training workshops will be held for the Hub & Spoke network. These sessions will focus on three

[11] The Substance Abuse and Mental Health Services Administration (SAMHSA). (2020). Retrieved from https://www.samhsa.gov/medication-assisted-treatment/become-buprenorphine-waivered-practitioner

central themes: alcohol and other substance use disorders in MAT, long-term MAT, and mental illness and MAT. These sessions will all be offered virtually.

- The Blueprint continued working with commercial payers to design payment approaches that would support Spoke nurses and licensed counselors like Medicaid. BlueCross BlueShield of Vermont and MVP Health Care implemented pilot approaches in 2019 and 2020. Process improvement for these payment pilots is ongoing as BlueCross BlueShield of Vermont and MVP Health Care continue identifying the best approaches to scale these pilots up to include more Spoke sites. In 2020 Medicare began paying for Hub and Spoke services due to changes in Federal law.
- To reduce the number of fatalities from drug overdoses, local Hub and Spoke leaders continue to expand access to treatment through what is known as rapid access to medication (RAM) by offering buprenorphine induction in more emergency departments across the state and making buprenorphine available at needle exchange sites.
- DVHA, through the Blueprint, has developed a study design in close partnership with the Department of Corrections (DOC) to evaluate continuity of MAT care for people returning to the community after incarceration. The memorandum of understanding that builds on the previous data sharing agreement between DVHA and DOC has been approved, and preliminary results are being analyzed. A complete report on the rates of continuity of care will be forthcoming in 2021.
- In 2020, in conjunction with ADAP, the Blueprint began working on a three-year pilot project with Yale University that aims to improve the frequency of HIV/HCV screenings and follow-up within the Hub & Spoke network. The initial implementation phase of the pilot with the first round of Hub & Spoke practices will begin early 2021.
- While adjusting to COVID-19, many of the Spoke staff worked with patients via telehealth. Most of the Spoke counselors have continued virtual visits through 2020, while some Spoke RNs began seeing patients in person as needed depending on the patients' levels of risk after the 2nd quarter of 2020. Due to the Medicaid MAT payment model, all Spoke staff were able to continue patient care throughout all of 2020.
- As a result of the ongoing changes with COVID-19, the Blueprint meets with VDH ADAP, DVHA Pharmacy, and DVHA Medicaid Transportation departments on a weekly basis to ensure successful coordination of care at the state.

Figure 7: Hub and Spoke Patient Counts for All Payers

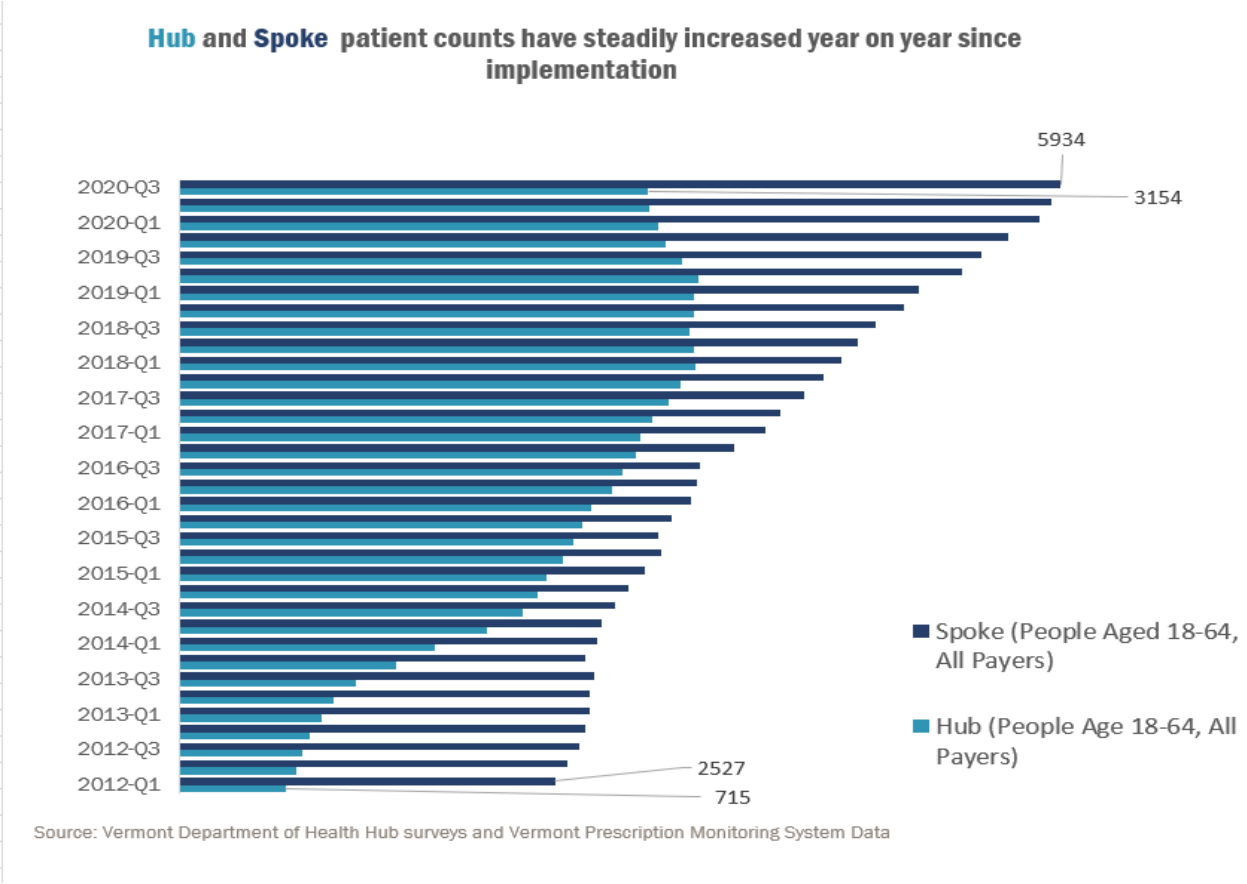
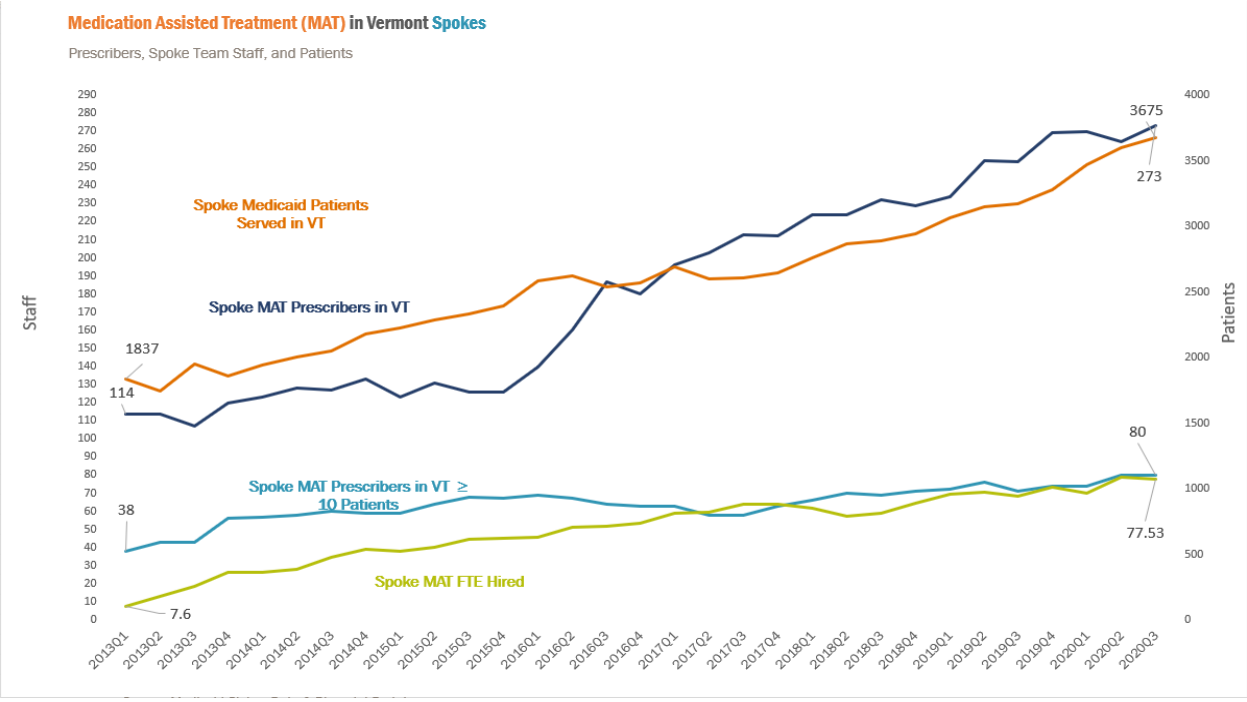
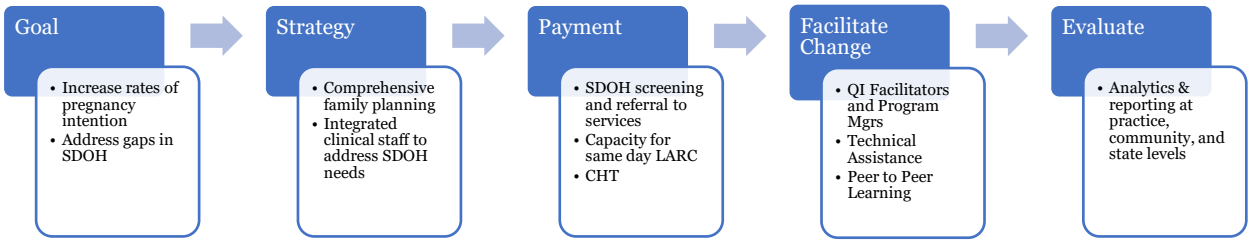


Figure 8: Medicaid Spoke Patients, Spoke Prescribers, and Spoke Staff



Women's Health Initiative

Figure 9: Women's Health Reforms



The Women's Health Initiative (WHI) strives to support Vermont women in their efforts to experience healthy pregnancies, avoid unintended pregnancies, and build thriving families. The Blueprint partners with women's specialty health providers and primary care practices, providing additional resources in support of the women they serve. In return, practices attest that they will provide enhanced screenings, brief interventions and referrals to treatment, initiate referral agreements with key community-based organizations in their HSA, conduct comprehensive family planning counseling, and provide patients with access to same day long-acting reversible contraception (LARC).

At a minimum, WHI providers engage with patients at new patient and annual visits to screen for social determinants of health needs including food and housing insecurity and interpersonal violence, as well as depression, anxiety, harm to self or others, and substance use disorders. They also discuss pregnancy intention for the coming year using the One Key Question®[12], which asks if, when, and under what circumstances a woman would like to become pregnant. Women with a desire to become pregnant receive services to support a healthy pregnancy. If the woman would like to prevent pregnancy, contraception methods are discussed and timely access to LARC is offered on site for the same day, if clinically indicated.

Like the core CHT and Spoke programs, the WHI provides increased mental health and social service staffing at specialty practices and utilizes the CHT at Blueprint PCMH practices. If a patient identifies as at-risk, they have immediate access to a WHI social worker for brief interventions, counseling, and navigation to community-based services and treatment as needed. WHI clinicians work closely with community partners and develop mutual referral agreements and establish meaningful relationships with those partners to support patients.

2020 Program Updates

WHI practices can access the program's central WHI Quality Improvement (QI) Facilitator to ensure the goals of the program are being met. In 2020, the QI Facilitator has systematically met with representatives from all WHI practices to identify process improvement opportunities, ensure the program elements are in place, and support improved patient experience of care.

Additional information about the Women's Health Initiative, including research supporting WHI goals and strategies and payments that support the work, can be found on the Blueprint for Health website[13].

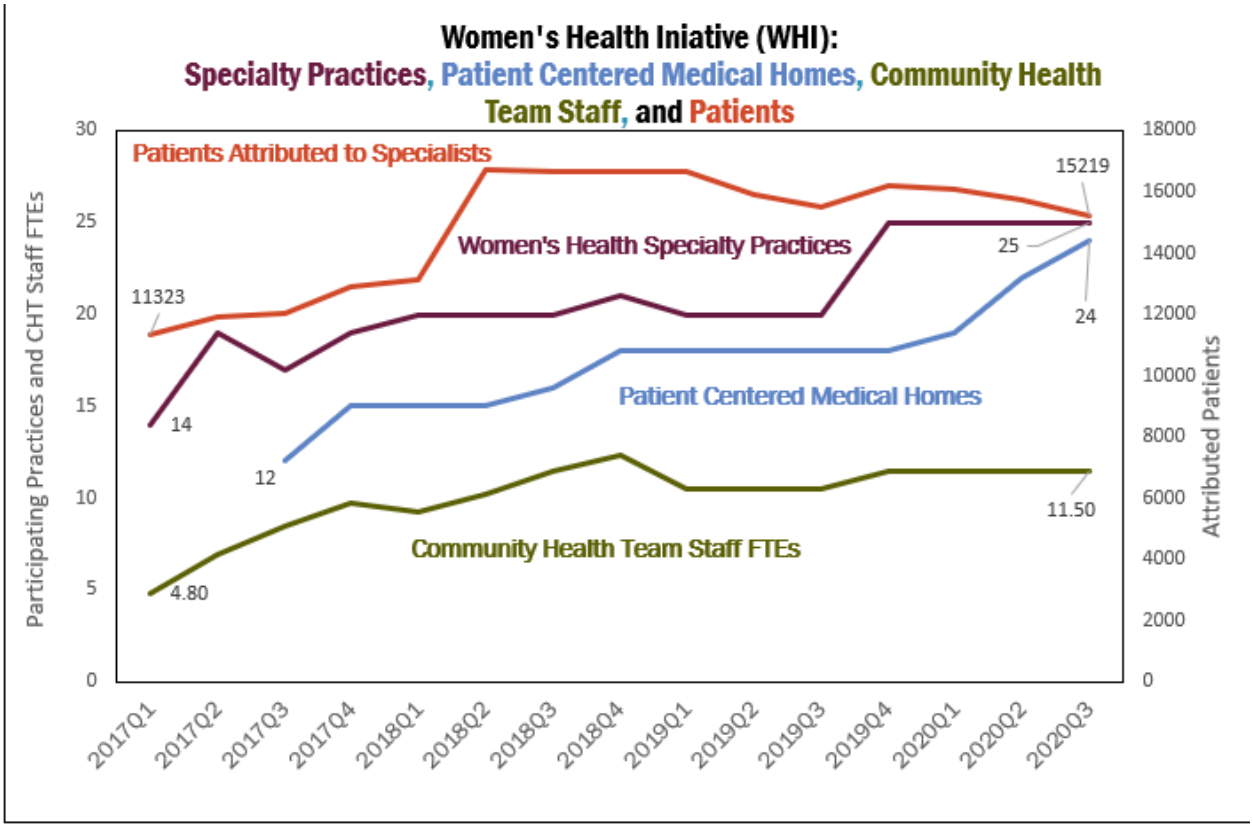
Figure 10 below shows WHI enrollment and staffing over time. In 2020, the number of PCMHs enrolled in the WHI increased, leading to more primary care practices conducting

[12] Power to Decide, One Key Question. (2020). Retrieved from https://powertodecide.org/one-key-question

[13] Blueprint for Health, Women's Health Initiative. (2020). Retrieved from https://blueprintforhealth.vermont.gov/about-blueprint/womens-health-initiative

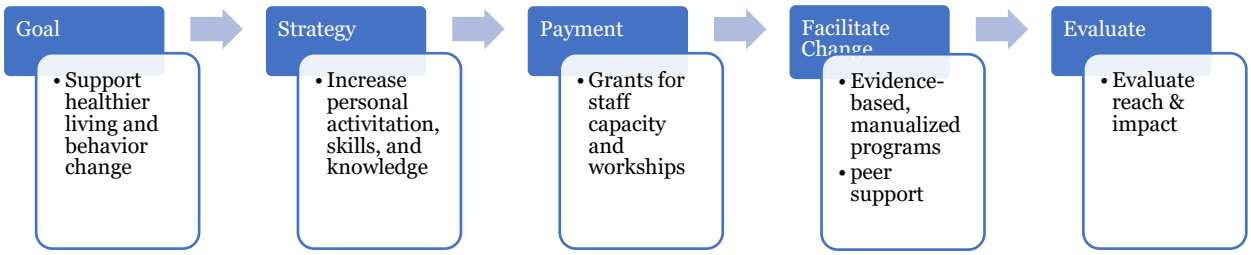
comprehensive SDOH screenings, initiating brief interventions and referrals to services when a need is indicated by a positive screen, providing comprehensive family planning, and offering same-day LARC when clinically appropriate.

Figure 10: WHI Enrollment and Staffing Over Time



Self-Management Programs

Figure 11: Self-Management Reforms



The Blueprint offers workshops that help people learn skills to better manage chronic conditions. Topics include healthy living with diabetes, diabetes prevention, tobacco cessation, mental health and emotional well-being, and living with chronic pain. Participants gain a better understanding of their health condition, explore their motivations, identify their strengths, and develop plans for achieving their health goals. They begin putting those plans into action with support from coaches and peers. The workshops last from four weeks to 12 months.

The Self-Management programs are also supported by the Vermont Department of Health, which supports the training of program leaders and marketing to potential participants. In

addition, Community Health Improvement at the University of Vermont Medical Center[14] offered statewide technical assistance and data collection via a contract with the Blueprint.

2020 Program Updates

In 2020, the Blueprint closely reviewed the programs offered and how they were administered and found that the programming was no longer achieving the same results as when they were introduced in 2008. While many workshops have successful outcomes, the number of participants has been declining over time and finding and maintaining workshop leaders has been difficult. Furthermore, providers are often reluctant to refer to workshops that may be waiting for an adequate number of participants before being scheduled. The Blueprint has also received feedback that many individuals are more interested in individualized offerings to improving health. Transportation, childcare, and work schedules were often barriers to in-person participation.

The Blueprint has therefore recommended narrowing the focus of the self-management resources to the early intervention in and management of hypertension and diabetes and the health risk factors and behaviors associated with these conditions. The self-management programs currently supported by the Blueprint cover a wide variety of conditions and minimizing the programs' subject matter will more efficiently meet the needs of the target population within the scope of the budget.

For 2021, the Blueprint will continue working with self-management stakeholders to revise the programming based on the most recent scientific recommendations as identified in a literature review conducted by VDH, as well as based on the findings from the ACO's research on patient activation, technology and incentives, and the Blueprint's findings from key informant interviews.

The following describes more in-depth literature reviews and key informant interviews that supported these recommendations.

Key Informant Interviews (Led by the Blueprint)

In the first month of the COVID-19 crisis the Blueprint was able to collect the following key informant interview findings through two primary care provider interviews, four individual and small group interviews engaging leaders and staff from Community Health Teams, local Self-Management Programs, and one informal focus group with CHT Leaders. Due to small sample sizes, the resulting insights should be used only directionally or with additional verification.

Summary of key informant interviews

- Weight loss is often the key change that could help, slow, or reverse disease progression. For that and many other reasons, providers want their patients to eat better and move more. Conversations about these goals can be uncomfortable.
- While nutrition and exercise classes are offered, many are homegrown by local leaders in response to community demand.
- Providers warned against assumptions that a patient understands these conditions in depth – e.g., what they do to one's body, why they are important to treat, and how behaviors can change the condition's progression. Customizing information is essential.

[14] Community Health Improvement at The University of Vermont Medical Center. (2020). Retrieved from https://www.uvmhealth.org/medcenter/departments-and-programs/community-health-improvement

- Understanding a patient's personal definition of health and their cultural context can help tailor effective interventions. New health behaviors may shift valued relationships, alternative sources of identity and belonging can support lasting change.
- Recognizing and capitalizing on the moments when people are especially ready for change is an important step – one example is getting a new prescription.
- Building confidence and creating small but concrete evidence that change is possible (e.g., testing blood sugar before and after taking a walk) can build momentum towards bigger shifts.
- Classes are effective because they are a shared experience, where participants witness and support each other. However, the prospect of engaging in a class can also feel daunting – some experience social anxiety or fear of exposure. Others have not taken a class since school and imagine being graded and judged.
- Many prefer to engage one-on-one with a coach. This personal support can be a complete intervention or the beginning of engagement with a broader range of self-management supports.
- Patients are ready to engage online – or can quickly become ready with support.
- Local leaders are ready to move beyond most of the current self-management offerings. The Diabetes Prevention Program continues to be relevant and useful. Workplace tobacco cessation has also shown promise.

Literature Review: prevention and management of diabetes and hypertension (led by VDH)

The Vermont Department of Health conducted extensive literature searches leading to:

- Identification of 880 articles about diabetes prevention, 20 studies reviewed
- Identification of 1,000 articles about diabetes management, 27 studies reviewed
- Identification of 66 articles about hypertension prevention, 6 studies reviewed
- Identification of 1,403 articles about hypertension management, 14 studies reviewed

Summary of diabetes prevention and management literature review findings

- Programs studied typically focused on physical activity and diet with the goal of modest weight loss.
- Within this focus, modalities varied but many demonstrated success.
- Several technology-assisted programs met or exceeded the CDC's Diabetes Prevention Recognition Program (DPRP) standards. Such programs should be considered to address participation barriers including transportation, childcare, and mobility.
- Successful programs followed the pattern of more weight loss during and directly after the intervention, followed by moderate weight regain. However, in most cases, type 2 diabetes risk reduction remained significant.

Summary of hypertension prevention and management literature review findings

- Like the diabetes prevention and management programs, study protocols typically focused on physical activity and nutrition to reduce risk factors.
- Successful programs were multi-modal. Self-monitoring was a critical component (but was not sufficient on its own). Other components of successful programs included clinical or community support and/or education or counseling.
- Some successful studies relied on pharmacists, nurses, or community health coaches working with physicians in a team-based care model to deliver interventions. Physician

skepticism was a barrier to program success but was overcome by demonstrating positive patient outcomes.

Literature Review: patient activation, use of technology, and use of incentives (led by the ACO)

The ACO conducted extensive literature searches, leading to:

- Identification of 136 patient activation articles, review of 93
- Identification of 24 technology articles, review of 24
- Identification of 49 incentives articles, review of 19

Summary of patient activation measure research

- The Patient Activation Measure (PAM) is a proprietary product that measures a patient's knowledge, skill, and confidence in managing their health and health care. It is the only validated, evidenced-based tailoring tool.
- For patients with hypertension, higher patient activation levels are associated with better medication adherence, knowledge of goal blood pressure, self-monitoring, and tracking via diary.
- Patient activation interventions can include motivational interviewing, audit and feedback, individualized care plans, and skill building. They have been shown to modestly improve A1c levels in adults with type 2 diabetes.
- PAM interventions are flexible and can happen in-person or via telehealth. They may also engage family or peer support.
- A personalized approach with tailored goals and/or action plans may address health literacy, problem-solving skills, depressive symptoms, hearing impairment, and more.

Summary of technology research (led by the ACO)

- Technology-supported interventions come in many flavors – from online programming that may include tailored learning paths, to patient portals, texting, apps, and even telephone calls.
- Success depends on the offering being more than education and information – that alone is insufficient to effect behavior.
- Technology-supported interventions are promising in their ability to both standardize and personalize learning and supports and they are scalable and cost effective.
- Asynchronous offerings help overcome participation barriers like work schedules, childcare availability, transportation, and mobility.
- People are more likely to stick with simpler technology-supported interventions.
- Downsides are few but include gaps in internet accessibility and variation in user comfort levels.

Summary of incentive research (led by the ACO)

- Incentives have two main roles – guiding the learning phase during the creation of habits and acknowledging efforts made in the stable phase.
- Incentives may help participants overcome barriers to activation participation. Some worry that they may unintentionally decrease intrinsic motivation.
- The CDC has endorsed use of food vouchers, transportation, gym memberships, and insurance premium discounts. Cash and gift cards to stores are also options.

Tobacco Cessation Self-Management

The Blueprint also recommended continuing support for active tobacco cessation programming through VDH. The Blueprint proposed collaborating with the VDH on researching new evidence-based group tobacco cessation programming, such as vaping prevention and management. However, this area of self-management reworking was put on pause at the beginning of the pandemic given VDH's ongoing work with contact tracing and other immediate COVID-19 management. The Blueprint plans to revisit this subject with VDH in 2021.

Response to COVID-19

The year 2020 was one of unprecedented challenge. Beginning in March when Governor Phil Scott declared a state of emergency in Vermont, Blueprint PMs, CHTs, PCMHs, specialty practices, and Spokes acted quickly to provide continuity of care for residents in their HSAs. The local Blueprint responses to the Covid-19 pandemic demonstrated the value of local networks supported with flexible funding. While the Blueprint Program Managers (PMs) and Community Health Teams (CHTs) have always been an integral part of their communities, the COVID-19 pandemic demonstrated how critical this highly integrated, community-based, healthcare coordination arrangement is in times of crisis. In every HSA across the state, Blueprint integrated care teams were called upon to quickly mobilize their region's response to the building Covid-19 pandemic. Julie Riffon, the Blueprint PM in Newport, expressed it succinctly:

> *"Most of the Blueprint Project Managers are very embedded in their community and the hospital system they work in. So, they would be the logical person for others to reach out to. A steady funding stream, skilled staff, and incredible leadership of program managers have been part of the 'fabric of life' in our communities. People turn to those they can trust in a crisis. We are so embedded in primary care that it is a natural connect."*

Providing localized, integrated, coordinated care and leadership is possible because of the funding structure for the CHT in each region. Blueprint HSA communities rely on stable funding that is not dependent on healthcare service utilization. That stable funding, combined with the understanding of each region's unique needs and other resources available in a community, provides the flexibility to fill service gaps as they develop. In this time of crisis, Administrative Entities were able to deploy their CHTs, Program Managers, and QI Facilitators as needed to meet emergent service gaps and avoid redundant or underutilized service capacity. To quote Tom Dougherty, Blueprint PM in Springfield,

> *"It seemed to happen sort of effortlessly because this is how we work. We didn't miss a beat. People were all there to do the work."*

Examples of roles the Blueprint HSA PMs played in their communities:

- Co-chaired a work group to find a permanent place for Covid-19 testing.
- Led the development and operations of local testing and Covid-19 Call Centers.
- Led the Community Collaborative group. This facilitation included communicating updates and requests to support each other with the needs of people living in the community. It also involved significant community outreach and working with different leadership groups.
- Facilitated relationships between Community Action, Designated Agencies, schools, Agency of Human Services, etc. With Blueprint support, these groups quickly came together with shared documents regarding meal sites, food distribution, testing, etc. The information was timely allowing people to learn about available resources and how to access them.
- Led and coordinated community agencies with a sense of hopefulness and pride in pulling efforts together for needed local resources.
- Facilitated meetings of the Covid-19 response team, which quickly developed committees to address community needs related to isolation, food security, economic resources, childcare and other resources for families.
- Joined incident command in hospitals, which involved:

- Connecting with families to answer questions.
- Supporting inpatient services such as making staffing decisions on how nurses would be deployed, setting up respiratory unit and a donning/doffing tent, and helping to set up a testing site.
- Sharing examples of how the CHT was able to provide support across sectors in community and bridge the divide between health and human services.
- CHT was dispersed to assist with other needed tasks at the hospital, backing up critical hospital services in case those staff got sick or were otherwise unable to work.

Figure 12: Randolph Area Mutual Aid Network sharing a message in the community.

In addition to meeting community organization needs, the Blueprint networks worked with practices to provide additional supports to patients. Most of the network used their electronic health records to run various reports based on key risk factors such as:

- Age greater than 60 with chronic conditions
- A John Hopkins' Adjusted Clinical Group (ACG) risk score indicating medical complexity or frailty.
- Potential for fragmented care
- Mental health and substance use diagnosis
- High healthcare resource usage

Figure 13: Supporting Vermonters with OUD during COVID-19 pandemic, contents of harm reduction packs developed and distributed in Lamoille County

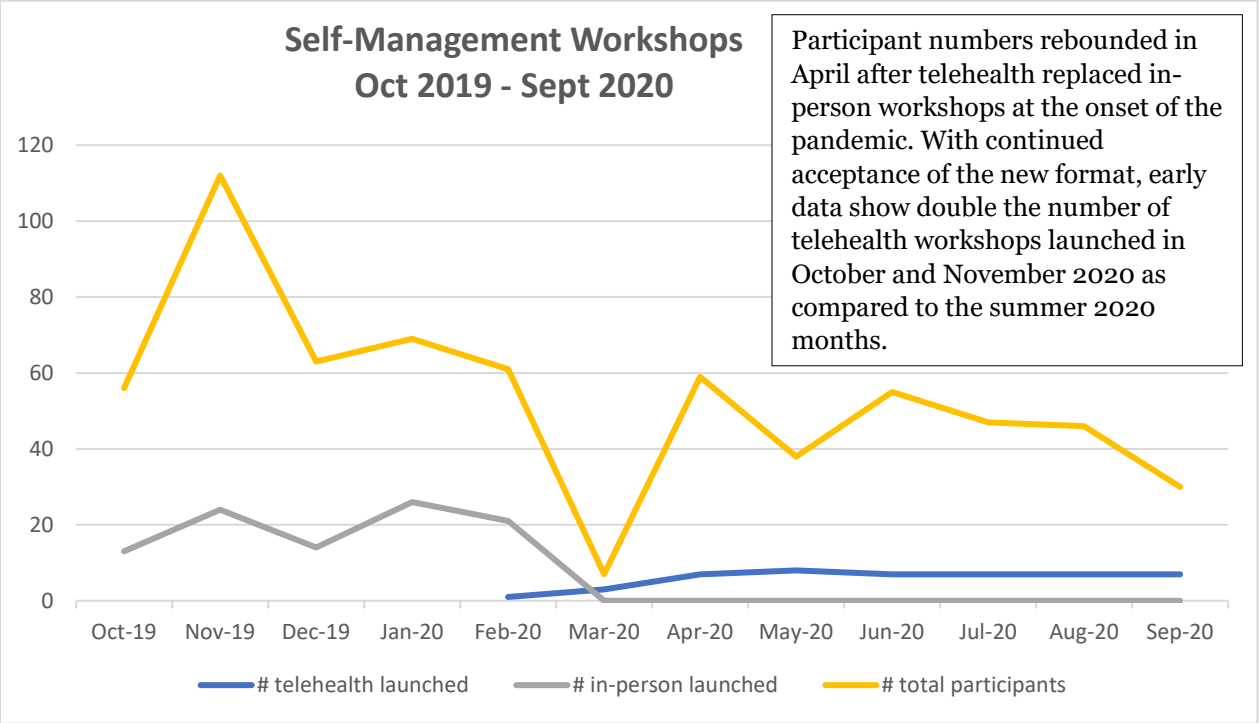
They also cross-referenced patients who missed appointments and who needed follow-up as soon as possible. The CHT staff reached out to the patients who met these criteria. On these calls, they would also inquire about other social determinants of health, such as access to food and medicine. While in-person visits have increased since the summer, telehealth continues to be an important option for primary care appointments and screenings as COVID-19 cases increased in the fall and winter of 2020. The network continues to work diligently to ensure excellent patient care and care coordination for the best health outcomes.

The Blueprint self-management program staff responded quickly to the needs of the community during the initial COVID-19 state of emergency. Some were deployed to direct patient care, while remaining staff completely redesigned the in-person group program to a virtual platform. Staff rapidly developed a total of 18 self-management workshops that launched during April and May, and new workshops were continually offered across the network for diabetes prevention,

tobacco cessation, and healthier living with chronic disease. The expansion of telehealth increased workshop options and the remote offerings increased access. While the number of workshops available has decreased since the beginning of the pandemic, those that are held are enrolled to capacity. Additionally, no virtual workshops have been cancelled thus far, while pre-pandemic a number of workshops were cancelled due to low enrollment numbers. Furthermore, virtual offerings have encouraged cross-HSA interactions and, anecdotally, participants have indicated that the increased access to self-management workshops allows for regular accountability with lifestyle changes and frequent group socialization.

As indicated in Figure 13 below, in-person self-management workshops were cancelled after March 2020 in accordance with COVID-19 guidance. During this time, regional coordinators quickly worked to launch self-management workshops in a virtual format and launched a total of 72 virtual workshops within the calendar year. The latest data also indicates 643 Vermonters completed self-management programs from October 2019 to September 2020. Participant and workshop data for October - December 2020 will be complete in 2021.

Figure 14: Self-Management Workshops Held October 2019 – September 2020



Blueprint central office staff supported field staff as the latter pivoted to emergency COVID-19 healthcare activities in their local communities and worked to keep Vermont's network of healthcare and human services providers economically viable throughout the pandemic. Many of Vermont's providers were already financially vulnerable going into the crisis, and the collapse of traditional fee-for-service payment streams pushed many organizations to the breaking point. Continued implementation of Blueprint capitated payments to PCMHs and CHTs provided steady and reliable sources of revenue and staffing for providers. Central office staff also shifted focus from many of their normal planning, analytic, and reporting activities to support implementation of the State's emergency economic relief programs for healthcare and human

services providers using federal Coronavirus Relief Funds (CRF). Between late July and early December of 2020, five Blueprint staff logged over 380 hours (or collectively more than 47 staff-days) assisting with the COVID-19 Hazard Pay and Health Care Stabilization grant programs administered by the Agency of Human Services (split across the two programs at 64 and 316 hours, respectively). Blueprint staff helped review and draft Frequently Asked Questions (FAQ) instructional documents that were updated multiple times a week on the program websites. They also responded via email to hundreds of potential applicants to answer questions and explain the application process and requirements. Finally, they provided phone support to a small number of applicants who needed extra assistance.

For the Hazard Pay program, two staff members devoted substantial hours to screening applications for eligibility and alerting applicants to missing information so that providers would have a chance to make corrections and resubmit prior to the deadlines. The goal for participation in these two grant programs was to support State efforts to keep essential workers and health and human service providers financially afloat throughout the crisis.

The Blueprint central office was also asked by Vermont Department of Health to respond to complaints to the COVID-19 hotline specific to patient experience related to PCMHs. For example, a person may call the hotline if a PCMH refused testing or a referral, or the person had concerns that their medical home was not following the current guidelines. Blueprint staff would then reach out to the practice manager or other identified designees to share concerns as well as up-to-date information on the guidelines for testing asymptomatic or symptomatic patients. While practices reported knowing this information, this communication allowed the practice to address any gaps in communication in their workflow and follow the guidelines for testing and /or referral.

Finally, the Blueprint central office staff researched and drafted a proposal in November and early December to use CRF funding to introduce on-demand COVID-19 virus testing resources and services into primary care practices throughout the state. In the end, the timeline was too tight to implement the plan and expend the CRF funds by the December 30, 2020 deadline, but the plans continue to be available for implementation in 2021 if and when longer-term funding mechanisms are available. The goal will be to integrate COVID-19 virus testing (particularly, specimen collection) into the normal workflows of primary care practices.

Blueprint Data and Analytics

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 though analysis of multi-payer claims and clinical data. In 2020, the Blueprint prioritized streamlining its evaluation efforts to integrate better with the healthcare evaluation activities of other state entities with the goal to increase coordination and efficiencies. The Blueprint's standalone claims and clinical data-analytics contract was terminated at the end of 2019, and evaluation tasks were divided by service population and redistributed to other contracts. 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. For analysis of Medicaid-primary populations, the Blueprint worked within DVHA to add Blueprint evaluation needs (such as the Medicaid Hub & Spoke Health Home measures and the Global Commitment (GC) Medicaid alternative payment model measures) to DVHA's existing Medicaid Healthcare Effectiveness

Data and Information Set (HEDIS) evaluation contract. Under these new partnered contracts, Blueprint claims and clinical data-analytic work resumed in December 2020.

In a similar streamlining and consolidation effort, the Blueprint terminated its longstanding contract for a standalone Vermont Clinical Registry (VCR) at the end of 2019 and worked to replace and improve upon that resource through the new collaborative data services initiative at Vermont Information Technology Leaders (VITL)[15]. The Blueprint uses clinical data from Electronic Health Record (EHR) systems to calculate hybrid claims/clinical healthcare quality measures. Blueprint staff participated in needs assessment, planning, work specification, and vendor selection for a new data warehouse at VITL to hold claims, clinical, and social determinants of health data. Vendor selection for the new VITL data warehouse was completed in the spring of 2020, and Blueprint staff then worked with VITL to further specify a new Blueprint clinical data extract from the system, with a target delivery date for calendar year 2020 data in the first half of 2021.

Finally, in another instance of data consolidation, the Blueprint rebuilt its provider-registry web database portal and moved it to a system hosted by VITL through one of VITL's subcontractors. (The underlying technology of the old Blueprint web portal, Adobe Flash, will no longer be supported on the web after 2020.) Most of the Blueprint's data analyses and payment systems rely on provider roster data from Blueprint-participating healthcare practices for the purposes of patient-to-provider and patient-to-organization attribution. Data from that system is populated by Blueprint field staff and then used by payers and analytics vendors for patient attribution. Now VITL staff have immediate and on-demand access to Blueprint provider and practice roster information, and the Blueprint has a more robust and flexible provider portal to support operations, payments, and evaluation.

Patient Experience of Care

Vermont state statute requires the Blueprint to report annually on the outcomes for patient experience of primary care. Since 2011, this task has been fulfilled through the administration of the Consumer Assessment of Health Providers and Systems Clinician and Group (CG-CAHPS) Survey with PCMH questions included. The outcomes for this survey provide the broadest statewide look at patient experience in Vermont. The results are also used to support PCMH recognition by the NCQA, and, most recently, as part of the quality reporting under payer contracts with OneCare Vermont for the All-Payer ACO Model.

In 2019, 121 PCMHs participated in the survey, which was an increase from 108 practices in 2018. These included family practices, pediatric practices, and internal medicine practices whose pediatric and/or adult patient populations served as the source for a random sampling of patients to whom the survey was mailed. In 2019, the number of surveys fielded was 54,051 with 9,299 adults and 1,813 pediatric patients responding. The combined response rate was 20.6%. A full report including the methodology and results from the 2019 patient experience survey is available at:
https://blueprintforhealth.vermont.gov/sites/bfh/files/doc_library/2019PatientExperienceWriteupFinal.pdf.

Overall Findings

Outcomes for the CG-CAHPS survey are often presented through composite measures, which represent the combined results for a group of related questions in the survey. The topics by

[15] Vermont Information Technology Leaders 2019 Annual Report. (2020). Retrieved from https://www.vitl.net/sites/default/files/VITL_2019AnnualReport_Final.pdf

which questions are grouped include:

- Access to care
- Communication between provider and patient
- Coordination of Care
- Information about the practice and appointments
- How helpful and courteous the Office staff were
- Support of Self-Management
- Access to Specialty Care

The following outcomes include a summary of the 2019 CG-CAHPS composite measure results by HSA (Table 2), a more detailed presentation of care coordination composite results, a summary of results over time for the state, and a summary of Vermont's outcomes relative to national benchmarks. Table 2 and Figures 15 and 16 display the combined percentage of respondents statewide and in each of the HSAs who answered "Always" or "Yes" to the questions included in the composite measures.

The darker and lighter shaded cells of the table indicate which HSAs had results significantly higher or lower than the rest of the state in each composite measure. The state average is provided for reference.

Table 2: 2019 CG-CAHPS composite measure results by HSA

	Access	Commun-ication	Coordination of Care	Infor-mation	Office Staff	Self Mgmt	Specialty Care
State Average % "Always" Response	**65.0%**	**87%**	**71%**	**67%**	**82%**	**54%**	**53%**
Barre	62.7%	86.6%	73.1%	66.4%	80.0%	52.9%	54.8%
Bennington	66.4%	89.6%	74.0%	72.5%	82.0%	56.6%	53.6%
Brattleboro	61.2%	89.8%	67.8%	65.0%	83.7%	50.8%	58.4%
Burlington	61.3%	87.3%	71.6%	66.6%	80.9%	55.2%	48.2%
Middlebury	72.3%	87.2%	71.9%	72.1%	86.9%	55.4%	51.5%
Morrisville	59.5%	85.5%	71.7%	62.7%	71.4%	52.4%	54.7%
Newport	71.5%	85.5%	70.1%	65.8%	81.9%	50.6%	62.4%
Randolph	68.7%	85.5%	69.4%	63.6%	86.7%	48.0%	52.6%
Rutland	70.3%	88.1%	75.6%	70.6%	82.9%	57.6%	54.2%
Springfield	65.1%	87.7%	70.2%	62.8%	77.3%	43.2%	58.9%
St Albans	66.8%	85.0%	69.9%	74.4%	82.1%	57.7%	53.3%
St. Johnsbury	61.7%	85.6%	72.4%	66.2%	84.6%	53.4%	54.3%
Windsor	64.7%	87.5%	72.0%	68.0%	84.2%	54.3%	53.7%

Legend:

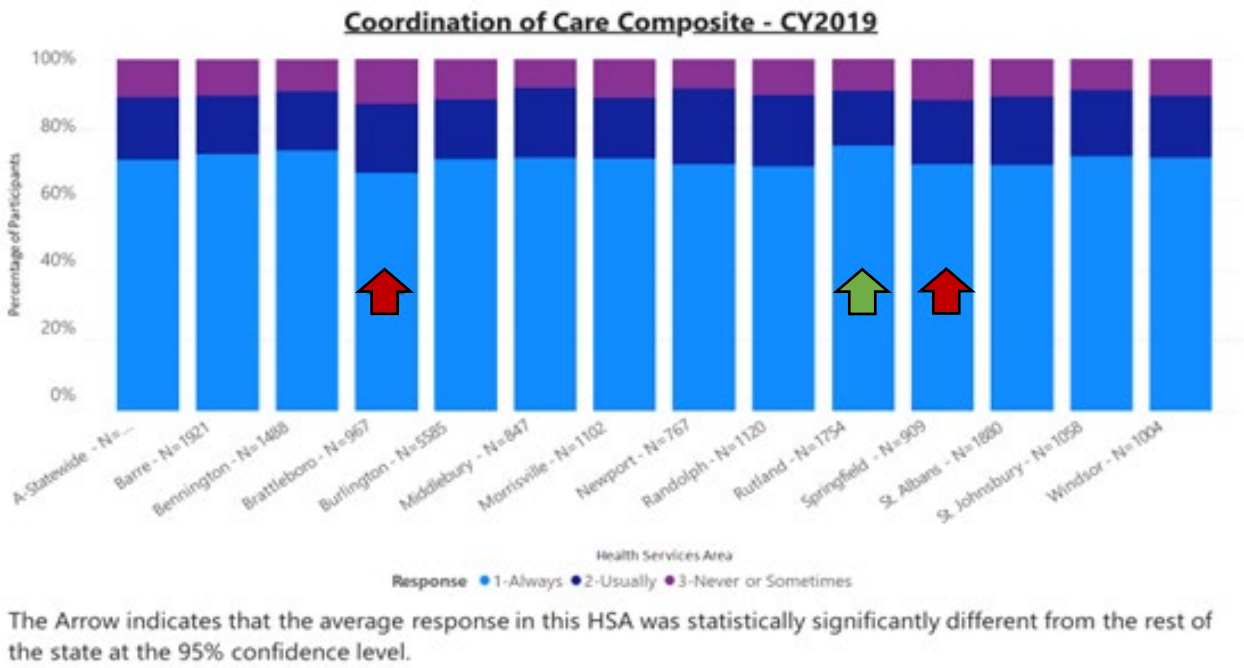
	Statistically lower than rest of the state
	Not statistically different from the rest of the state
	Statistically higher than rest of state

Coordination of Care

The below chart uses the Care Coordination composite as an example of the full data available in the report referenced above. The composite on Coordination of Care provides feedback on how well care is coordinated, specifically how aware the primary care provider was of medical history, prescriptions, and testing. It includes the following questions:

- In the last 6 months, how often did this provider seem to know the importance about your medical history?
- In the last 6 months when this provider offered a blood test, x-ray, or other test for you, how often did someone from this provider's office follow up to give you those results?
- In the last 6 months, how often did you and someone from this provider's office talk at each
- Figure 15 below shows that the proportion who responded "Always" ranged from 68% (Brattleboro) to 76% (Rutland) with a statewide average of 72%. Only three HSAs were statistically different than the rest of the state. These included Rutland having a statistically higher proportion that responded "Always", and Springfield and Brattleboro having statistically higher proportions that responded, "Never or Sometimes".

Figure 15: 2019 Coordination of Care Composite by HSA

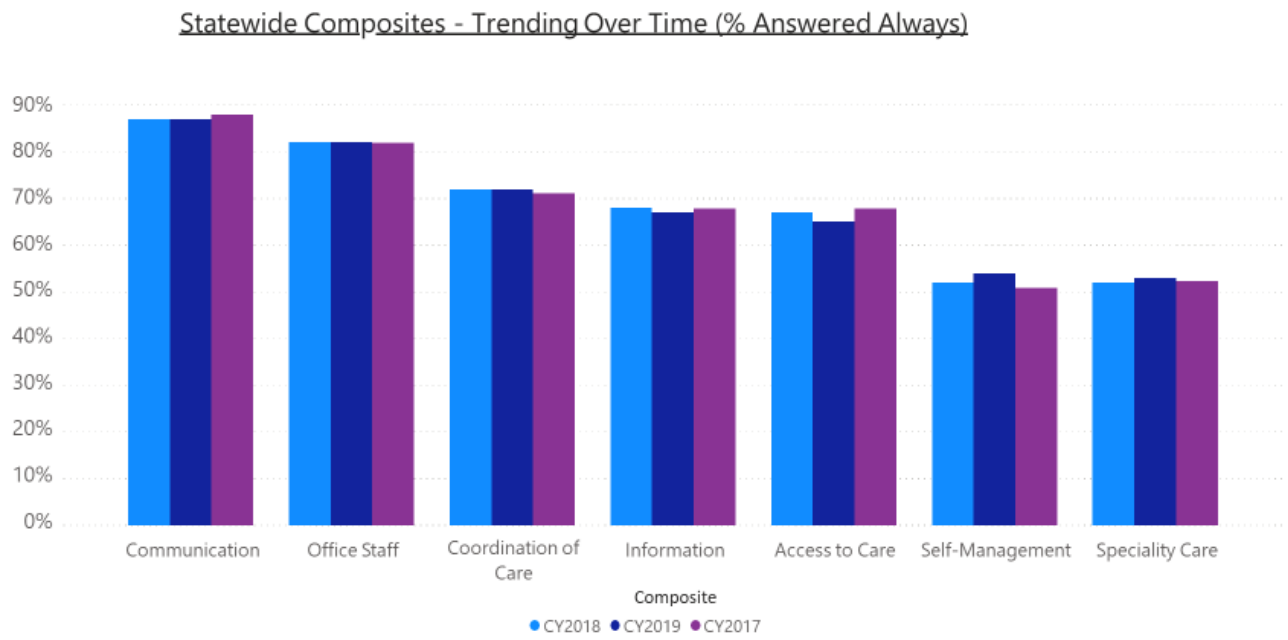


The Arrow indicates that the average response in this HSA was statistically significantly different from the rest of the state at the 95% confidence level.

Trending Over Time: Vermont Composite Results for 2017, 2018, and 2019

Figure 7 shows the statewide performance in each of the composite over the last three years. Statistical significance testing was not conducted on the results; however, there appears to be little variation across years – proportions answering "Always" or "Yes" change less than 3 percentage points from year to year.

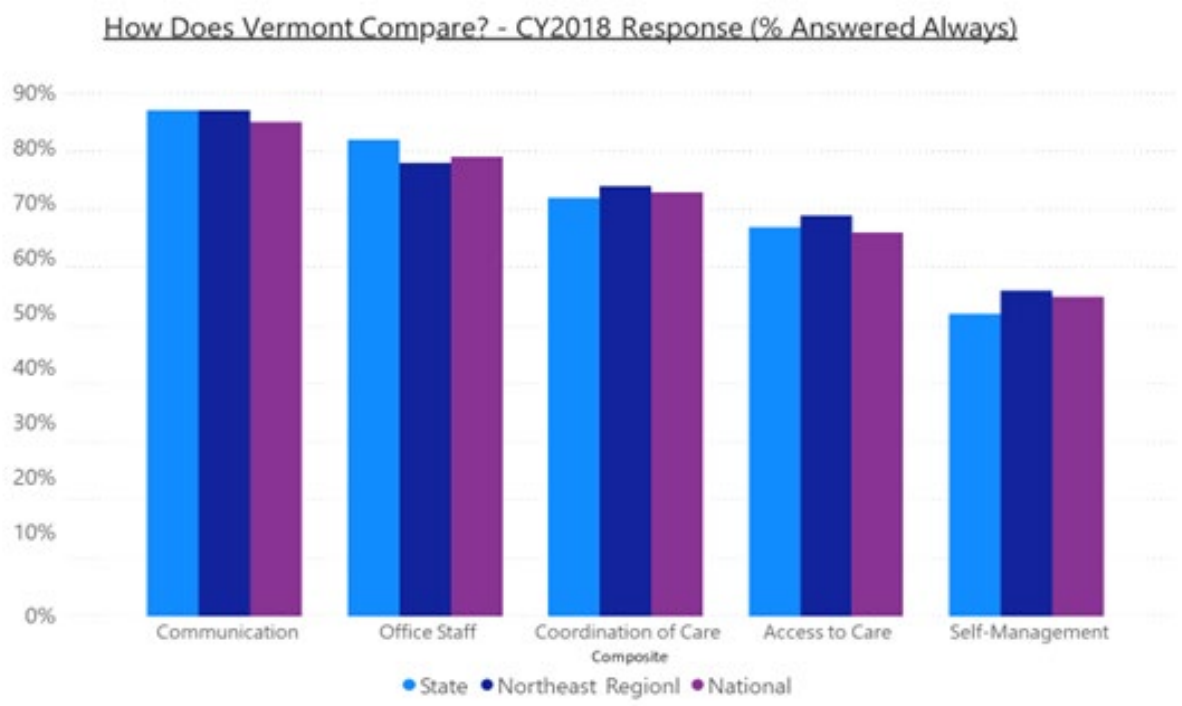
Figure 16: Statewide Composites, Trending Over Time



Comparison to National & Regional Benchmarks

Finally, this report compares Vermont's 2018 performance to the national benchmarks for 2018 (the most recent year for which the benchmarks are available; Figure 8). For Communication, Office Staff, and Access to Care composite, Vermont appears be higher than the national average while lower in the Coordination of Care and Self-Management composites. However, when looking at the regional data, Vermont is lower in all categories except Office Staff and Communication, indicating that relative to the state's neighbors, the state has room for improvement.

Figure 17: 2018 Vermont Performance to National Benchmarks



Health Service Areas (HSAs) At-a-Glance

The following sections provide 13 local portraits of the staffing capacity for care integration and coordination and key activities undertaken in the 2020 year. These attempt to provide more information about how care is coordinated locally and reflect the spirit of support and partnership of the Blueprint program implementation.

The Blueprint HSAs, led by Blueprint Program Managers, were asked to share some summary data and an overview of activities in their communities including Major 2020 Achievements and projects in 2020. The section below includes their responses beginning with a high-level summary of the care management landscape across HSAs.

Regional Infrastructure

The structure of the Community Health Team (CHT) Care Management is unique to each Health Service Area, depending on the needs and resources of each region. Generally, CHTs are either fully embedded or operate in a centralized /embedded hybrid model. Embedded care managers are located at primary care practices and, for the Hub and Spoke initiative, in substance use treatment centers. CHT staff also support specialty clinics, including Planned Parenthood, in the Women's Health Initiative. While the fully embedded CHT model is most often used, some care managers operate out of a central location such as a hospital or are field-based and meet with patients in their homes or other community locations. CHT staff include social workers, mental health counselors, licensed drug and alcohol counselors, nurses, dieticians, diabetes educators, community health workers, and resource coordinators. In addition, Self-Management Regional Coordinators support staffing for self-management programs that address smoking and other chronic health conditions. CHT staff are hired directly by the practice with pass-through funding, contracted by the local designated agency, or employed by the Administrative Entity (i.e., hospital or FQHC). While funding for staffing primarily comes from Medicaid, Medicare, BlueCross BlueShield of Vermont, MVP, and Cigna, some dollars also flow from the OneCare Vermont ACO for specific positions as well as the local Administrative Entity, which may augment salaries for staffing.

Coordination

As care management systems have grown in the regions, so has the need to coordinate among participating organizations. Each HSA has Blueprint-led meetings designed to strategize how care management activities are implemented and to discuss patient-level care planning. Communities may additionally choose to work on addressing specific issues such reducing rates of obesity, reducing rates of homelessness, transitions of care, suicide by drug overdose, and other social determinants of health concerns that impact their community. The cadence of these meetings ranges from weekly to monthly, with more frequent meetings tending to focus on care planning and less frequent meetings focused on strengthening cross organizational referral relationships, improving communication to avoid duplicative efforts, sharing lessons learned, and identifying and addressing barriers to receiving or providing care.

Examples of organizations present at these meetings include the local hospitals, CHT leadership, designated mental health agencies, Area Agencies on Aging, SASH, FQHCs, home health agencies, and the ACO. This diverse group represents fields of service that address physical health, mental health, substance use, and social needs.

Goals

While the HSAs have a remarkable track record of rolling out state-led healthcare reform

initiatives and effectively addressing the diverse needs of their patient population, more work can be done to improve coordination of services, alignment across healthcare reform initiatives, and use of data and tools. The areas of improvement expressed by HSA networks generally translated to two goals: 1) Develop sufficient resources to support the additional care management requirements associated with the ACO-attributed patients; and 2) Reduce the redundancies and gaps experienced with the use of multiple care management information systems and different reporting and incentive structures required by multiple organizations.

The CHTs work with all patients who need services regardless of the patient's medical coverage. This approach has been a hallmark of the Blueprint model for many years. With the addition of the OneCare VT ACO, administrators must work to meet specific care quality and outcome targets for ACO-attributed patients; at the same time, they must continue to serve the full patient panel seen in practices. Improving the alignment between and incentives for the ACO, Blueprint, and practices' goals for complex care management is needed to ensure that decisions are based on clinical criteria and not administrative directives. This area of improvement is consistent with Finding 15 of the Implementation Improvement Plan[16] , which states "AHS, OneCare Vermont, and community providers should improve collaboration to strengthen integrated primary, specialty, and community-based care models for people with complex medical needs and medical and social needs." Additionally, without appropriate support and alignment between payers and programs, CHT resources can become stretched beyond capacity in the effort to meet all needs.

Related to the second goal, Finding 12 of the Implementation Improvement Plan highlighted the need to improve the efficacy of Care Navigator, the ACO's care management information system. Currently Care Navigator is used for a sub-set of the CHT patient population. Due to this arrangement, CHT staff often must enter data in redundant information systems, which pulls resources away from direct patient care. HSA leaders also note that not all members of a care team, depending on the organization they work for, can access Care Navigator. This limitation decreases the ability to coordinate care effectively leading to frustration and lack of information across providers.

These goals are possible – many of the key elements such as community connections, staffing, and funding mechanisms currently exist. The call for alignment in the Implementation Improvement Plan will require communities to look carefully at these available resources and achieve greater consensus about how they can more effectively fit together. The shift of the Blueprint to the Vermont Agency of Human Services Office of Health Care Reform will better position the central team to support this goal.

HSA-at-a-Glance Tables

A note regarding the tables in the below reports: One point to keep in mind when reading the "The Blueprint and ACO Payer Participation" tables is that they summarize the different health care reform initiatives in which practices participate; however, the ACO and Blueprint columns have slightly different implications that should be called out. The columns for ACO represent the ACO payer programs in which a practice participates. This information provides an indication of the portion of the practice's patient population attributed to the OneCare VT ACO. The greater the participation, the greater the number of patients attributed to the ACO. Of note, the choice of participation is not always up to the individual practices, particularly if they are hospital-owned.

[16] IMPLEMENTATION IMPROVEMENT PLAN: Vermont All-Payer Accountable Care Organization Model Agreement November 19, 2020 Retrieved from https://humanservices.vermont.gov/sites/ahsnew/files/doc_library/APM%20Implementation%20Improvement%20Plan%20Final%2011.19.20.pdf

The columns for Blueprint initiatives indicate which practices participate in which initiatives, but a key difference from the ACO columns is that participation applies to all of a practice's patient population regardless of payer. For example, PCMH activities and CHT services are available to all patients seen in that practice. Additionally, practices will only participate in those initiatives that align with their practice type and patient population needs. For example, internal medicine practices are unlikely to participate in the WHI, and women's health specialty practices would not seek PCMH recognition since their services do not align with NCQA requirements. **The goal of the table is not to assess how well a practice is engaged in health care reform efforts, but instead it is meant to provide the reader with an idea of the level of ACO and Blueprint presence at the community level.**

For the HSAs "By the Numbers" tables, the HSA counts for the total population, the Blueprint-attributed population, the ACO-attributed population, and the percent of Blueprint-attributed also attributed to the ACO were calculated from the 2019 data in VHCURE, Vermont's all-payer claims database. This year is the most recent full year available in that database. This source has a couple limitations. First, it does not have ACO attribution data for 2020 and, therefore, the numbers reported in these tables will be lower than attribution currently reported by the ACO. Secondly, the VHCURES source is also limited by the available data. While it includes data from approximately two-thirds of Vermonters, it does not include many self-insured commercial plans, federal employee health plans, and military and veteran health plans. It also does not include information on individuals who are uninsured or self-pay. However, the decision was made to use the VHCURES data to present related data from a consistent source, timeframe, and methodology.

Barre Health Service Area

Program Manager: Mark Young

Barre by the Numbers

50,113	Heath Service Area Total Population
33,167	Blueprint Practices Patient Attribution
10,076	Total Accountable Care Organization (ACO) patient attribution, including non-Blueprint
23.1%	% of Blueprint-Attributed attributed to ACO
19.7	Community Health Team staff full time equivalents (FTEs)
6.9	Spoke staff FTEs
1	Women's Health Initiative staff FTEs
8	Self-management workshops held
45	Self-management workshop graduates
12,500	Community Health Team encounters
240	Patients served in area Spokes (Medicaid only)

Barre Community Health Team

Barre Blueprint Practices Blueprint and ACO Payer Participation

Parent Organization	Practice Site Name	ACO Participation				PCMH	WHI	Spoke
		Medicaid	Medicare	BCBSVT	MVP			
Independent	Tree of Life Medicine	-	-	-	-	X	-	-
Independent	Green Mountain Wellness Solutions, Inc.	X	-	X	X	X	-	-
CVMC	Adult Primary Care - Barre	X	X	X	X	X		X
CVMC	Family Medicine - Berlin	X	X	X	X	X	X	
CVMC	Family Medicine - Mad River	X	X	X	X	X	-	X
CVMC	Family Medicine - Waterbury	X	X	X	X	X	-	X
CVMC	Integrative Family Medicine - Montpelier	X	X	X	X	X	-	-
CVMC	Pediatric Primary Care - Berlin	X	X	X	X	X	-	-
CVMC	Women's Health	X	X	X	X	-	X	-
CVMC	Green Mountain Family Practice	X	X	X	X	X	-	X
The Plainfield Health Center	The Health Center	X	X	X	X	X	-	-
UVMC	UVMHN CVMC Family Medicine - Berlin - Main Campus	X	X	X	X	X	-	X
Treatment Associates	Treatment Associates-Montpelier	-	-	-	-	-	-	X

Major 2020 Achievements

THRIVE, the Central Vermont Accountable Community for Healthcare (ACH), was instrumental in **standing up an emergency response** that provided support and resources to prevent hospital surge during the COVID-19 pandemic. The Washington and Northern Orange Counties Regional Response Command Center (WNOC-RRCC) grew to a 'staff' of nearly 20 volunteer collaborators, including our Blueprint Quality Improvement Facilitator, and was informed by CVMC's Emergency Operations Center. WNOC-RRCC provided 846 volunteer hours, 30,449 meals, medical support and assistance for 318 people in General Assistance (GA), supported and emergency housing, a Community Call Center, and donated goods including masks and hand sanitizer.

THRIVE continues to support groups emerging from WNOC-RRCC, including: a Connectivity Project providing resources to overcome the 'digital divide'; access to food through the local THRIVE-supported Everyone Eats program (CVMC is a distribution site); a Homelessness Task Force addressing homelessness supports over the winter and long-term, and a Medical Team supporting temporarily-housed and unhoused homeless, including a primary care access pilot involving CVMC primary care and CHT to assess and expedite access to primary care services.

Additional Featured Projects

The WHI CHT staff at CVMC Women's Health created and have been co-facilitating a **Perinatal Mood and Anxiety Disorders support group call The Baby Circle Group**. It was created and is supported through a collaboration with Women's Health, Good Beginnings of Central Vermont, The Family Center of Washington County, and other community groups. The group has a process for achieving joint consent among community partners, shared resources toward advertising, and has pivoted to a virtual platform during the COVID-19 pandemic. The group currently has 20 registered members and 5-6 weekly participants.

Bennington Health Service Area

Program Manager: Kristi Cross

Bennington by the Numbers

30,193	Heath Service Area Total Population
20,026	Blueprint Practices Patient Attribution
7,102	Total Accountable Care Organization (ACO) patient attribution, including non-Blueprint
29.4%	% of Blueprint-Attributed attributed to ACO
7.9	Community Health Team staff full time equivalents (FTEs)
7.3	Spoke staff FTEs
0.5	Women's Health Initiative staff FTEs
4	Self-management workshops held
11	Self-management workshop graduates
13,320	Community Health Team encounters
387	Patients served in area Spokes (Medicaid only)

Bennington Community Health Team

Bennington Blueprint Practices Blueprint and ACO Payer Participation

Parent Organization	Practice Site Name	ACO Participation				PCMH	WHI	Spoke
		Medicaid	Medicare	BCBSVT	MVP			
Independent	Battenkill Valley Health Center	-	-	-	-	X	-	X
Independent	Brookside Pediatrics and Adolescent Medicine	-	-	-	-	X	X	-
Independent	Keith Michl, MD	-	-	-	-	X	-	-
Independent	Green Mountain Pediatrics	X	-	X	X	X	-	-
Independent	Avery Wood, MD	X	X	X	X	X	X	-
Independent	Eric Seyferth, MD	X	X	X	X	X	-	
Independent	Shaftsbury Medical Associates	X	X	X	X	X	-	X
Primary Care Health Partners	Mount Anthony Primary Care	X	X	X	X	X	-	X
SVMC	Deerfield Valley Campus	X	X	X	X	X	-	X
SVMC	Internal Medicine	X	X	X	X	X	-	-
SVMC	Northshire Campus	X	X	X	X	X	-	-
SVMC	OB GYN	X	X	X	X		X	-
SVMC	Pediatrics	X	X	X	X	X	-	-
SVMC	Pownal Campus	X	X	X	X	X	-	-
SaVida	SaVida-Bennington	-	-	-	-	-	-	X

Major 2020 Achievements

All Blueprint practices received NCQA PCMH recognition. Despite the challenges of the COVID-19 pandemic, the Bennington HSA continued to spend considerable time and effort in meeting the goals of complex care coordination of OneCare VT and established **OneCare VT Partner Collaboration Workgroup**. The workgroup has been instrumental in aligning all OneCare VT participating organizations of the Bennington HSA. We also created a Bennington OneCare VT Work Plan that has been shared with OneCare VT and other HSAs.

Additional Featured Projects

Many of our featured projects in 2019 were placed on hold for 2020 due to the COVID-19 pandemic. In the early stages of COVID-19 in Vermont, the ability to pull together the members of the Bennington Community Collaborative for **emergency community meetings** was both humbling and pivotal for our community. The established Bennington Community Collaborative allowed a seamless and efficient method for gathering key leaders across all sectors of the community. It created a space for communication, support, and guidance during a critical time.

Despite the unprecedented challenges of COVID-19, the Bennington HSA was able to stay steadfast in the development of project planning for the Community Action Grant. The Community Action Grant is a $175,000 grant to the Bennington HSA to be used towards **opioid overdose prevention**. We met the deadlines and created many innovative strategies worthy of praise. We are very excited to implement the next steps towards keeping our community healthy and saving lives.

Brattleboro Health Service Area

Program Manager: Rebecca Burns

Brattleboro by the Numbers

24,268	Heath Service Area Total Population
13,917	Blueprint Practices Patient Attribution
4,458	Total Accountable Care Organization (ACO) patient attribution, including non-Blueprint
25.3%	% of Blueprint-Attributed attributed to ACO
7.5	Community Health Team staff full time equivalents (FTEs)
3.2	Spoke staff FTEs
0.5	Women's Health Initiative staff FTEs
21	Self-management workshops held
63	Self-management workshop graduates
5,000	Community Health Team encounters
170	Patients served in area Spokes (Medicaid only)

Brattleboro Community Health Team

Brattleboro Blueprint Practices Blueprint and ACO Participation

Parent Organization	Practice Site Name	ACO Participation				PCMH	WHI	Spoke
		Medicaid	Medicare	BCBSVT	MVP			
Grace Cottage Hospital	Grace Cottage Family Health	-	-	-	-	X	-	X
Habit OPCO	Southeast HUB - Brattleboro	-	-	-	-	-	-	-
Independent Practice	Biologic Integrative Healthcare	-	-	-	-	X	-	-
BMH / SVHSC	Family Medicine	X	X	X	X	X	-	-
BMH / SVHSC	Internal Medicine	X	X	X	X	X	-	-
BMH / SVHSC	OB/GYN	X	X	X	X	-	X	-
BMH / SVHSC	Maplewood Family Practice	X	X	X	X	X	-	-
BMH / SVHSC	Putney Family Healthcare	X	X	X	X	X	-	-
BMH / SVHSC	Windham Family Practice	X	X	X	X	X	-	-
Retreat Health Care	Southeast HUB - Brattleboro	X	X	X	X	-	-	-
Primary Care Health Partners	Brattleboro Primary Care	X	X	X	X	X	-	

Major 2020 Achievements

We were able to start collaborating with a Nurse Practitioner who specializes in **Diabetes Management**. He is onsite at BMH weekly and provides telehealth visits as well when he is not onsite. Our CHT has been working very closely with him, providing wrap around services to work with folks to lower their HgA1C's. This has been a huge accomplishment for our CHT and our community.

The WHI team was able to adjust workflows when visits were shifting away from in person visits. There were concerns about the SDOH screening not being done in a timely manner as the team was mailing the screening form. They decided the best course of action was to have the WHI social worker call the women and do the SDOH over the phone and provide **on the spot brief interventions** to be sure that women were being supported and not falling through the cracks of the healthcare system. This was a huge shift to how it was being done previously.

Additional Featured Projects

The CHT provided a lot of **support to the COVID-19 response** and this where most of our time has been spent. Several staff were redeployed to be hospital screeners and COVID-19 testers. The CHT building housed the testing site from March- June and the Blueprint Program Manager oversaw the testing site as well. The team was ready to respond with whatever the community needed, including mobile testing for our community partners. Our care coordinator worked to support all the primary care practices, while their RN's were redeployed to work in the hospital to assist with surge planning. The CHT continued to provide tele-visits to community members. This allowed folks to receive care in the safety of their homes. We had several patients advise us of how amazing it was to be able to do this!

Burlington Health Service Area

Program Manager: Kerry Sullivan

Burlington by the Numbers

126,181	Heath Service Area Total Population
93,120	Blueprint Practices Patient Attribution
31,195	Total Accountable Care Organization (ACO) patient attribution, including non-Blueprint
28.9%	% of Blueprint-Attributed attributed to ACO
46.3	Community Health Team staff full time equivalents (FTEs)
20.7	Spoke staff FTEs
2	Women's Health Initiative staff FTEs
6	Self-management workshops held
22	Self-management workshop graduates
15,753	Community Health Team encounters
1,023	Patients served in area Spokes (Medicaid only)

Burlington Community Health Team

Burlington Blueprint Practices Blueprint and ACO Participation

Parent Organization	Practice Site Name	ACO Participation				PCMH	WHI	Spoke
		Medicaid	Medicare	BCBSVT	MVP			
Independent Practice	Affiliates in OB/Gyn	-	-	-	-	-	X	X
Independent Practice	Champlain Obstetrics and Gynecology	-	-	-	-	-	X	-
Independent Practice	Frank Landry MD PLC	-	-	-	-	X	-	-
Independent Practice	Champlain Center for Natural Medicine	X	-	X	X	X	X	-
Independent Practice	Lakeside Pediatrics; PLLC	X	-	X	X	X	-	-
Independent Practice	Mountain View Natural Medicine - Colchester	X	-	X	X	X	-	-
Independent Practice	Mountain View Natural Medicine - So. Burlington	X	-	X	X	X	-	-
Independent Practice	Pediatric Medicine	X	-	X	X	X	-	-
Independent Practice	Lund	-	-	-	-	-	-	X
Independent Practice	Vermont Integrative and Naturopathic Medicine (JMS; PLC)	X	-	X	X	X	-	-
Phoenix Houses of New England	Phoenix House-Burlington	-	-	-	-	-	-	X
CHCB	Champlain Islands Health Center	X	X	X	X	X	-	X
CHCB	Good Health	X	X	X	X	X	-	X
CHCB	Pearl Street Youth Health Center	X	X	X	X	X	-	X
CHCB	Riverside Health Center	X	X	X	X	X	X	X
CHCB	Safe Harbor Health Center	X	X	X	X	X	-	X
CHCB	South End Health Center	X	X	X	X	X	-	X
CHCB	Winooski Family Health	X	X	X	X	X	-	X
Evergreen Family Health	Alder Brook Family Health	X	X	X	X	X	-	-
Evergreen Family Health	Charlotte Health Center	X	X	X	X	X	-	-
Evergreen Family Health	Evergreen Family Health	X	X	X	X	X	-	X
Howard Center	NW Hub-Chittenden Clinic	X	X	X	X	-	-	-
Howard Center	Safe Recovery	-	-	-	-	-	-	X
Independent Practice	Dr. Hebert	X	X	X	X	X	-	-
Independent Practice	Essex Pediatrics	X	X	X	X	X	-	-
Independent Practice	Gene Moore	X	X	X	X	X	-	X
Independent Practice	Green Mountain Internal Medicine; PLC	X	X	X	X	X	-	X
Independent Practice	Richmond Family Medicine	X	X	X	X	X	-	-
Independent Practice	Thomas Chittenden Health Care (TCHC)	X	X	X	X	X	-	X
Primary Care Health Partners	Timber Lane Milton Pediatrics	X	X	X	X	X	-	-
Primary Care Health Partners	Timber Lane North Pediatrics	X	X	X	X	X	-	-
Primary Care Health Partners	Timber Lane Pediatrics	X	X	X	X	X	-	-
UVMMC	Appletree Bay Primary Care	X	X	X	X	X	-	X
UVMMC	Adult Primary Care -	X	X	X	X	X	-	X

	Burlington							
UVMMC	Adult Primary Care - Essex	X	X	X	X	X	-	X
UVMMC	Adult Primary Care - South Burlington	X	X	X	X	X	-	X
UVMMC	Adult Primary Care - Williston	X	X	X	X	X	-	X
UVMMC	Family Medicine - Colchester	X	X	X	X	X	-	-
UVMMC	Family Medicine - Hinesburg	X	X	X	X	X	-	-
UVMMC	UVMMC Family Medicine – Milton	X	X	X	X	X	-	X
UVMMC	Family Medicine - South Burlington	X	X	X	X	X	-	X
UVMMC	Obstetrics and Midwifery	X	X	X	X	-	X	X
UVMMC	Pediatric Primary Care - Burlington	X	X	X	X	X	-	X
UVMMC	Pediatric Primary Care – Williston	X	X	X	X	X	-	X
UVMMC	ATP	-	-	-	-	-	-	X
UVMMC	Alicia Cunningham, MD	-	-	-	-	-	-	X

Major 2020 Achievements

Community Health Centers of Burlington (CHCB) has been participating for all of 2019 and 2020 in the Vermont Department of Health's Chronic Disease Prevention Initiative. CHCB works in partnership with Bi-State Primary Care Association and a Blueprint QI Facilitator to address continuous systems-level improvement to reduce the burden of chronic disease on Vermonters by supporting diabetes and prediabetes identification, management, and control with referral to self-management and prevention programming. In the late fall of 2020, they developed a **bi-directional referral process for CHCB dental and medical patients with prediabetes.**

Another achievement this year was the use of **Patient Portals**. Along with further developing processes/protocols for telehealth options for patients, several of the primary care practices took action to use Patient Portals. The portal creates efficiency for both the patient and the practice because it also allows for scheduling appointments, accessing health records, and helping patients monitor their own care. Together the ability for practices to enhance care by telehealth and patient portals in the same year has been a note-worthy achievement.

This year saw our community come together in many ways to face the challenges the year presented. One major achievement was the ability for **all practices to quickly pivot to using telehealth** at the start of the pandemic. Many of the practices had only minimally engaged in this method of care previously, but amazingly with a continuous flow of information shared as quickly as possible regarding payment flexibility and protocol, all were able to adapt quickly to make sure patient care was minimally interrupted. This provided opportunity for our community to continue to provide excellent care at an appropriate level. The practices then flexed again to engage quickly around new COVID-19 testing processes and how to deliver flu shots. Information sharing and having established networks for support in place was essential. Additionally, the fact that the funding for Patient-Centered Medical Homes, the MAT Program and Women's Health Initiative was unchanged, allowed for stability with staffing to provide essential care. Often clinicians hired with these funds were asked to flex their roles as well, but that fact that the funding was there and unaffected brought a quiet strength to many practices.

The pandemic certainly affected every aspect of our healthcare system this year, and an additional **challenge of a Cyberattack at UVM Medical Center** brought yet another significant incident to our system. The impacts of this were far reaching beyond the walls of the Medical Center as the ability for independent practices to see patient discharges, access labs and more were all impacted. Our Community Health Team Administrative Team was called into action to support as part of the effort in

ensure patient needs were met. The team called all patients who had been discharged from the hospital to make sure they were clear on their discharge instructions regarding follow up care and helped them to make connections to provider offices to ensure those appointments were made. That is one example of the level of creativity and flexibility that was taken during a truly remarkable time.

Additional Featured Projects

The Chittenden Accountable Community for Health Core team (CACH) continued to meet regularly. The CACH team committed to continuing to ground the larger team in Suicide Prevention efforts. They continue to work on three aspects of Suicide Prevention within the county. The team also breaks up into action teams and the following highlights work to date and accomplishments of each Action Team.

1. Screening and Intervention Action Team

- Identified and selected the tools needed to support primary care practices to engage in a quality improvement project related to screening for suicidality and establishing a pathway to care (i.e., ASQ, C-SSRS, Suicide Prevention Toolkit for Primary Practices, specific Zero Suicide data measures and workflows for practices to collect and share data);
- Created a survey to send out to each primary practice in the county to obtain foundational information to assist with selecting pilot practices;
- Created an executive summary for the project with supporting research;
- Identified grant opportunities to fund work with primary practices;
- Worked with the Center for Outcomes Research and Education by participating in the "Data Across Sectors for Health" mentor program.

2. **Reducing Stigma Action Team**

- Submitted a service project proposal to Leadership Champlain and was selected for the 2020-2021 cohort;
- Work with 5 Leadership Champlain cohort members to determine how to measure stigma in the county, determine why individuals do not seek mental health support when they are at high risk for suicidality and how to address stigma in the community through meaningful action steps;
- Created a Public Service Announcement (PSA) related to supporting community members in crisis and how to access help (texting VT to 741741) when needed. The PSA is currently broadcast on one radio station;
- Collaborate with the Department of Mental Health (DMH) to evaluate the effectiveness of the PSA by way of data analysis. DMH collects data on community use of texting VT to 741741.

3. **Social Connectedness Action Team**

- Created an AIM statement and Primary Drivers to guide work;
- The Action Team chose to support and amplify the efforts of mentor organizations across the county;
- Through a collaborative effort with mentor organizations, it was decided to focus on recruitment and training;
- Worked with mentor organizations to develop a list of new mentor trainings;
- Developed a plan on how to create one centralized training platform for all mentor organizations in the county to utilize. Developed a plan for recruitment amongst all Action Team member organizations and other organizations.

Middlebury Health Service Area

Program Manager: Sylvie Choiniere

Middlebury by the Numbers

21,200	Heath Service Area Total Population
15,927	Blueprint Practices Patient Attribution
5,009	Total Accountable Care Organization (ACO) patient attribution, including non-Blueprint
27.0%	% of Blueprint-Attributed attributed to ACO
6.6	Community Health Team staff full time equivalents (FTEs)
2.5	Spoke staff FTEs
0.75	Women's Health Initiative staff FTEs
5	Self-management workshops held
12	Self-management workshop graduates
4,000	Community Health Team encounters
168	Patients served in area Spokes (Medicaid only)

Middlebury Community Health Team

Middlebury Blueprint Practices Blueprint and ACO Participation

Parent Organization	Practice Site Name	ACO Participation				PCMH	WHI	SPOKE
		Medicaid	Medicare	BCBSVT	MVP			
Independent Practice	Rainbow Pediatrics	X	-	X	X	X	-	-
Independent Practice	Vermont Natural Family Health - Salisbury	X	-	X	X	X	-	-
Independent Practice	Middlebury Family Health Center	X	X	X	X	X	-	-
Independent Practice	Mountain Health Center	X	X	X	X	X	-	X
Planned Parenthood of Northern New England	PPNNE - Middlebury	X	X	X	X		-	-
Porter Medical Center	UVM Health Network Porter Medical Center Pediatric Primary Care	X	X	X	X	X	-	-
Porter Medical Center	UVM Health Network Porter Medical Center Primary Care Brandon	X	X	X	X	X	-	-
Porter Medical Center	UVM Health Network Porter Medical Center Primary Care Middlebury	X	X	X	X	X	-	-
Porter Medical Center	UVM Health Network Porter Medical Center Primary Care Vergennes	X	X	X	X	X	-	X
Porter Medical Center	UVM Health Network Porter Medical Center Women's Health	X	X	X	X	-	X	-

Major 2020 Achievements

During the past year, several accomplishments were achieved specially focusing on chronic conditions and substance use. Two initiatives to address chronic conditions included the expansion of the **Farmacy Program and the Food Bags pilot project**. The Farmacy project expanded from 30 Porter participants in 2019 to 60 participants in 2020. The expansion of this program was supported by hospital leadership as well as the OneCare VT Value Based Incentive Funding in which the community agreed upon supporting more food shares. This year was an opportune time as there was a greater need for food and nutrition due to the COVID-19 pandemic. Participants received food shares for 12 weeks between July-September, along with resources and nutrition education. As for the Food Bags, this project was piloted at Porter Women's Health and facilitated by the CHT Registered Dieticians and the embedded WHI Social Worker. These bags contained healthy non-perishable food items that were intended to last a family of 4, for 2-3 days until they could access other resources in the community. The bags were completed with a food resource guide for Addison County and dental supplies (toothbrushes, toothpaste, and floss).

Medication-Assisted Treatment (MAT) for Opioid Use Disorder (OUD) is a well-supported initiative from the Blueprint, and the community has taken action to help support this effort. Mountain Health Center made their **mobile unit available for MAT services** to increase access in areas outside of Bristol, their main location. Unfortunately, due to COVID-19, this mobile unit was placed on hold due to the limited internal space but has proven successful during its first few months. Additionally, **Rapid Access to MAT** was started at Porter Hospital in January 2020, in collaboration with SaVida and Turning Point Center (TPC). All of the doctors in the Emergency Department (ED) were x-waivered and patients seen in the ED for OUD were treated and immediately referred to SaVida in Vergennes to be seen within 3 days and connected with a peer recovery coach from TPC.

Additional Featured Projects

The local Accountable Community for Health – CHAT or the Community Health Action Team focused on 2 main projects including the **Hydration Campaign for older Vermonters and Resiliency Campaign for youth**.

- Hydration Campaign started as a project to help encourage Older Vermonters to drink more water and fluids in which often help prevent falls or dehydration leading to hospital visits. Residents at SASH sites as well as individuals being served by Home Health, Long-Term Care Facilities, and Adult Day Cares received water bottles with "Sip Don't Trip" logos to remind them to drink water. Additionally, resources regarding Falls Preventions and magnets were distributed as a visual reminder. Anecdotally, individuals enjoyed these clear water bottles so they could see how much water they drank, and it helped keep them on track.
- The Resiliency Campaign, "OK, You've Got This" is a continued effort throughout the past two years that have significantly expanded. The impact of COVID-19 added another layer of stress on families and youth, and community partners supporting this effort including the Designated Agency, Health Department, Parent Child Center, Department for Children and Families, and local schools, refocused efforts to support family needs during this time. The campaign has shifted to "Ok, We've Got This", symbolizing the efforts that the community is in this together. During the past few months, additional resources were made available to parents, to support children accessing school from home, and parents needing tools to discuss the pandemic and social distancing. In addition, monthly mini webinars were developed surrounding mindfulness, stress management, activities for families, SMART goals, and much more. This campaign continues to expand and seek other opportunities to support youth and families.
- Other Major 2020 Achievements included housing, transportation, and addressing chronic conditions. Addison County Community Trust was able to secure funding and build a 36 affordable housing unit in Vergennes, VT. This is already at full capacity and can accommodate both single and family needs. In early 2020, Porter Hospital in collaboration with Tri-Valley Transit, was awarded a Rides to Wellness Grant and gas cards were distributed to several health and wellness offices including Primary Care, SaVida, Turning Point Center, and the Health Department to help individuals physically access these resources. Lastly, several self-management programs were transitioned to telehealth to support individuals with chronic conditions during the COVID-19 pandemic and helped reach more folks who may have had transportation issues in the past. Similarly, primary care practices adapted to meet the needs of patients in a time of social distancing and continue to provide and expand telehealth services.

Morrisville Health Service Area

Program Managers: Hannah Ancel and Elise McKenna

Morrisville by the Numbers

21,306	Heath Service Area Total Population
14,740	Blueprint Practices Patient Attribution
1,643	Total Accountable Care Organization (ACO) patient attribution, including non-Blueprint
8.2%	% of Blueprint-Attributed attributed to ACO
7.3	Community Health Team staff full time equivalents (FTEs)
3.8	Spoke staff FTEs
0.5	Women's Health Initiative staff FTEs
2	Self-management workshops held
9	Self-management workshop graduates
2,528	Community Health Team encounters
258	Patients served in area Spokes (Medicaid only)

Morrisville Community Health Team

Morrisville Blueprint Practices Blueprint and ACO Participation

Parent Organization	Practice Site Name	ACO Participation				PCMH	WHI	Spoke
		Medicaid	Medicare	BCBSVT	MVP			
Independent Practice	Family Practice Associates	-	-	-	-	X	-	X
Independent Practice	Stowe Natural Family Wellness	-	-	-	-	X	-	-
Independent Practice	Stowe Personalized Medical Care PLLC	-	-	-	-	X	-	-
Independent Practice	Tamarack Family Medicine	X	-	-	X	X	X	X
Community Health Services of Lamoille Valley (CHSLV)	Appleseed Pediatrics	X	-	-	X	X	-	-
CHSLV	Morrisville Family Health Care	X	-	-	X	X	X	X
CHSLV	Stowe Family Practice	X	-	-	X	X	X	X
Copley Hospital	The Women's Center	X	-	-	-	-	X	-
Northern Counties Health Care	Hardwick Area Health Center	X	-	X	X	X	X	X
Treatment Associates	Treatment Associates-Morrisville	-	-	-	-	-	-	X
SaVida	SaVida-Morrisville	-	-	-	-	-	-	-

Major 2020 Achievements

COVID 19 Response – Collaborative Leadership: From the onset of the COVID 19 pandemic, leadership from diverse organizations recognized the need to come together to have a coordinated and collaborative response. Our Blueprint funded staff have played active roles in multiple community collaborative efforts to address the needs in our community, including the Medical Unit leader position for our region's incident command system. Our hospital and PCMH leadership have worked together to ensure a continued quality system of care even in the midst of the pandemic response. These collaborations have brought together key stakeholders to address the needs of specific populations during the pandemic including those who are homeless and those at-risk for opioid overdose.

- **Care Coordination for Homeless:** During the COVID 19 pandemic the State of Vermont has been providing funding to pay for hotel rooms for those who would otherwise be homeless to allow them to have a safe place to socially distance and stay healthy. Many, if not all, of the residents of the hotels are experiencing multiple challenges in their lives as well as medical complexity. Community partners have been working together to connect these community members to services, including providing flu shots on site. CHT and MAT team members have been making visits to the hotels in Lamoille County to assist in connecting residents to care.
- **Harm Reduction Packs:** Prior to the pandemic, community partners lead by the North Central Vermont Recovery Center were distributing Harm Reduction Packs funded by the Vermont Department of Health to help reduce the risk of opioid overdoes. As we were seeing families becoming more isolated and at-risk during the pandemic, the MAT team suggested it would be a good time to do a large push to distribute more Harm Reduction Packs with a particular focus on providing information to connect families to services and reduce their risk of COVID-19 exposure. The kits were modified with hand sanitizer and masks along with handouts about services. In total, 590 Harm Reduction Packs were distributed.

Additional Featured Projects

- **Zero Suicide:** Through the work of the Zero Suicide Community Action Network over 75 mental health professionals have been trained in Collaborative Assessment and Management of Suicide (CAMS) in our

community. In September, a panel from the Zero Suicide group presented at the Annual Vermont Suicide Prevention Symposium on the work being done in Lamoille Valley.

- **Addressing Food Insecurity – Bounty Share, Grocery Gift Cards & Everyone Eats with Flu Clinics:** During the pandemic Community Health Services of Lamoille Valley (CHLSV) has been able to leverage partnerships, existing programs, and additional funding made available in the pandemic response to offer multiple food assistance options to patients experiencing food insecurity. The Bounty Share program provides fresh, gleaned produce from local farms collected by Salvation farms and gathered into boxes for patients. CHSLV offers this to patients who share that they are experiencing food insecurity with their provider or through our social determinants of health screening. The Everyone Eats statewide program purchases meals made by restaurants using at least 10% locally sources ingredients to feed Vermonters who have been impacted by COVID - 19. CHSLV has distributed the meals along with our flu vaccination clinics as well as making them available in our waiting room to any patients who need. For patients who need immediate support getting groceries, the CHT offers a grocery store gift card to purchase nutritious foods for their family through a CARES grant in partnership with Capstone which is an Emergency Food and Shelter Program. This CARES grant was a collaboration submitted with CHSLV and the Lamoille Restorative Center. It was for a total of $12,375 for food assistance in response to the pandemic in Lamoille County. The flexibility in this funding allows some community members to cook with whole foods, some to receive already-prepared meals because cooking is a challenge, and others to have the flexibility of going to the grocery store to pick out food that fits their needs.

Newport Health Service Area

Program Manager: Julie Riffon

Newport by the Numbers

21,751	Heath Service Area Total Population
15,428	Blueprint Practices Patient Attribution
4,396	Total Accountable Care Organization (ACO) patient attribution, including non-Blueprint
26.0%	% of Blueprint-Attributed attributed to ACO
4.3	Community Health Team staff full time equivalents (FTEs)
0.6	Spoke staff FTEs
0	Women's Health Initiative staff FTEs
6	Self-management workshops held
15	Self-management workshop graduates
5,594	Community Health Team encounters
128	Patients served in area Spokes (Medicaid only)

Newport Community Health Team

Newport Blueprint Practices Blueprint and ACO Participation

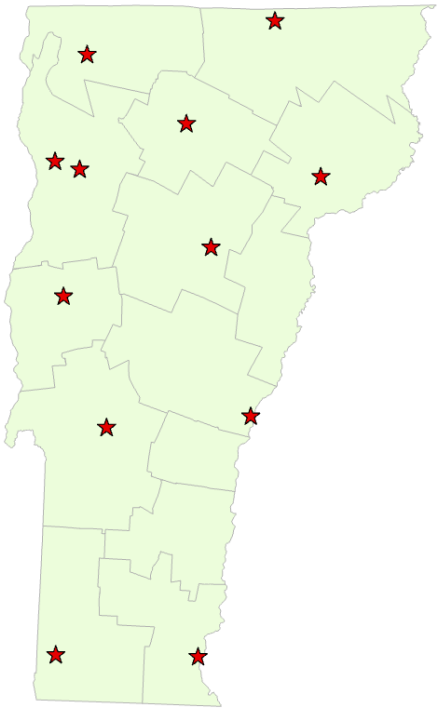
Parent Organization	Practice Site Name	ACO Participation				PCMH	WHI	Spoke
		Medicaid	Medicare	BCBSVT	MVP			
BAART Programs	Northeast Hub -	-	-	-	-	-	-	-
North Country Health Systems	Pediatrics	X	-	X	X	X	-	-
North Country Health Systems	Primary Care Barton Orleans	X	-	X	X	X	-	-
North Country Health Systems	Primary Care Newport	X	-	X	X	X	-	-
Northern Counties Health Care	Island Pond Health Center	X	-	X	X	X	-	-
SaVida	SaVida-Newport	-	-	-	-	-	-	X

Major 2020 Achievements

- Despite the pandemic, Newport's CHT continued to provide a significant positive impact on our community by providing **1714 activities directly linked to Newport's Community Health Needs Assessment implementation strategies.** These include actions to support mental wellness, substance free, tobacco free lifestyles, healthy eating, increased physical activity, access to medical and oral health care and aging in place.
- Newport's CHT successfully completed **on-time transition to the ACO's new care coordination payment requirement** with 414 attributed lives meeting the required Care Navigator documentation resulting in receiving the new payments. This includes maximizing Zoom for the required Care Team Conferences.

Additional Featured Projects

- During the first COVID-19 wave NCH's medical practices, with Newport's CHT staff playing an important role, continued to safely provide care to 8,090 patients in the modality they preferred. The goal was to provide patient-centered care and **decrease unnecessary Emergency Department use**, enabling the Emergency Department to focus on its COVID-19 surge response.
- Our pediatric & two primary care practices successfully **achieved annual NCQA PCMH recognition** on time despite the pandemic. This was the result of significant efforts in standardization of processes, workflows and quality initiatives embedded in the practices that continued despite the new demands of responding to COVID-19.

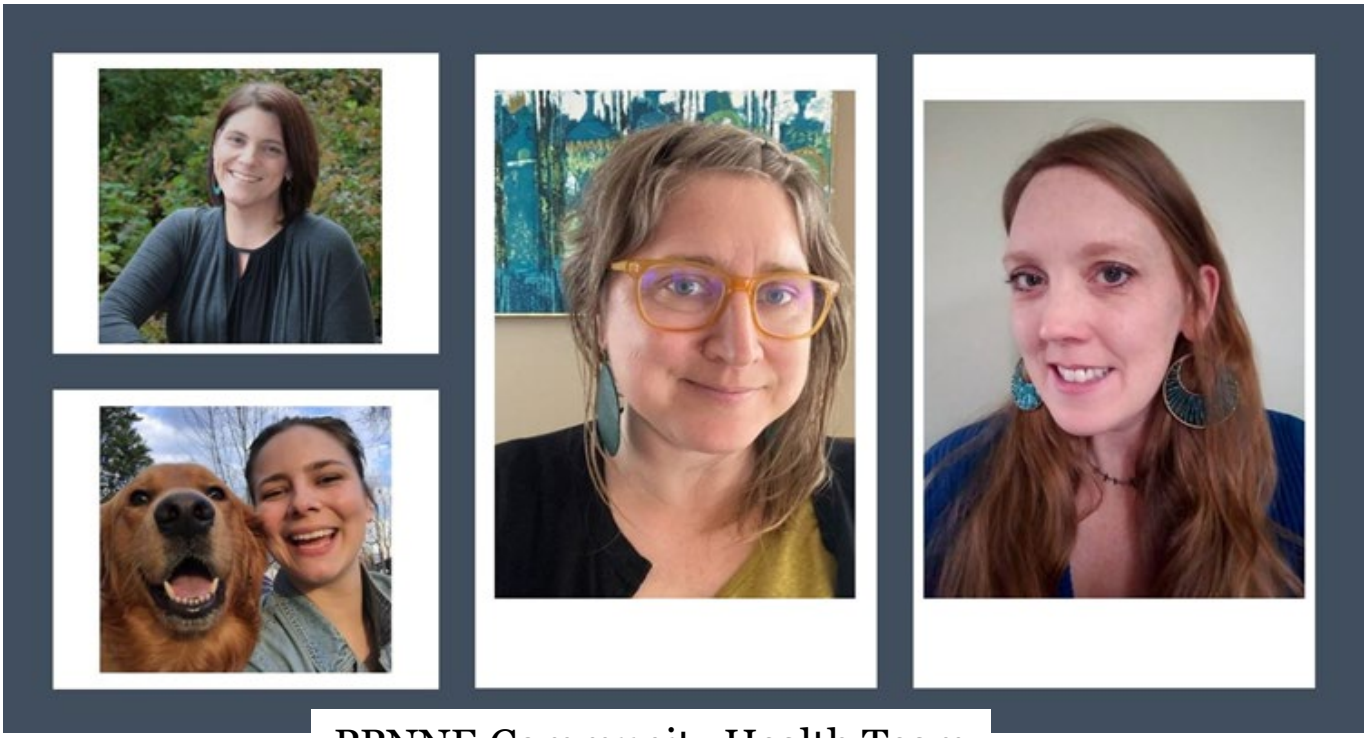


Planned Parenthood of New England (PPNNE)

Program Manager: Shauna Hill

PPNNE by the Numbers

2.0	Women's Health Initiative staff FTEs
5318	Attributed patients statewide



PPNNE Community Health Team

PPNNE Blueprint Practices Blueprint and ACO Participation

Parent Organization	Practice Site Name	ACO Participation				PCMH	WHI	Spoke
		Medicaid	Medicare	BCBSVT	MVP			
Planned Parenthood of Northern New England	PPNNE - Barre	X	X	X	X	-	X	-
	PPNNE - Bennington	X	X	X	X	-	X	-
	PPNNE - Brattleboro	X	X	X	X	-	X	-
	PPNNE - Burlington	X	X	X	X	-	X	-
	PPNNE - Hyde Park	X	X	X	X	-	X	-
	PPNNE - Newport	X	X	X	X	-	X	-
	PPNNE - St. Albans	X	X	X	X	-	X	-
	PPNNE - St. Johnsbury	X	X	X	X	-	X	-
	PPNNE - White River Junction	X	X	X	X	-	X	-
	PPNNE - Williston	X	X	X	X	-	X	-

PPNNE Goal

Build a high-engagement, equity-rooted integrated mental health and substance use disorder program for PPNNE patients that accelerates resilience, improves health outcomes, and improves pregnancy intention in the communities we serve.

Major 2020 Achievements

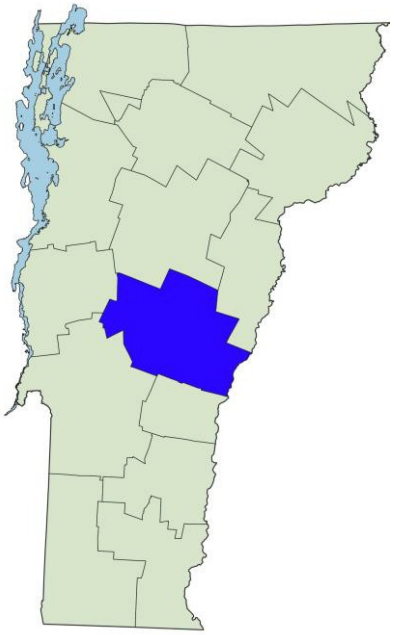
In December 2020, **PPNNE began state-wide expansion** our 4-site Women's Health Initiative pilot project to all 12 of our Vermont health centers with the hire of a state Director of Behavioral Health. The arrival of the COVID-19 pandemic shifted project timelines and allowed a rapid integration of telehealth into our Blueprint-funded CHT services in Burlington, Middlebury, Williston, and Rutland health centers. Despite dramatic drops in patient care volumes during Vermont's spring stay-at-home order, our Integrated Behavioral Health Social Work (IBHSW) staff were able to continue offering all CHT clinical and care management services in a telehealth-only model using phone and video conferencing platforms during the acute phases of virus surge in Vermont to the patients who did seek care at PPNNE. The **rapid shift to telehealth** also allowed us the opportunity to formalize a CHT service model that dramatically reduces common barriers to care access such as transportation, lack of childcare, and scheduling challenges, and we will continue integrated telehealth CHT services moving forward.

In response to the increased complex psycho-social and SDOH needs of our patients, PPNNE WHI staff worked with the Blueprint to allow inter-regional emergency/same-day support to patients in urgent referral need at all 12 participating practices before new expansion CHT staff could be hired and embedded locally. PPNNE leadership and WHI staff re-designed our initial IBHSW project plans to focus on a robust telehealth service coverage model that now provides access to another PPNNE CHT by all health center staff & patients state-wide on every day of clinic care we offer in times of designated CHT absence or unavailability. This 'back up' CHT coverage model also allows us to manage our staff resources and balance the needs of each individual clinic, as well as the community and resource development and advocacy work that serves our Vermont patients more broadly.

In fall 2020 we launched our expansion hire for four additional WHI social workers to be embedded in our remaining service regions: Northeast (St. Johnsbury, Newport & Hyde Park clinics), Northwest (St. Albans & Williston), Central (Barre & White River Junction), and South (Bennington & Brattleboro), with our Northeast and Northwest CHTs beginning work in early December. From January through November 30, 2020, PPNNE WHI-funded CHTs provided patients with 620 direct clinical hours of WHI care in Burlington, Williston, Middlebury & Rutland. PPNNE screened 99%--nearly 1100 patients—at their annual visits for depression, suicidality, Screening, Brief Intervention, and Referral to Treatment (SBIRT) needs, intimate partner violence and SDOH resource needs, with 31% screening positive for depression, and 11% of those patients screening for positive suicidality and receiving supportive intervention and referral.

Additional Featured Projects

- PPNNE WHI staff worked in consultation with population health and other internal departments to begin expansion of translated forms & patient education materials to better serve our patients with Limited English Proficiency (LEP).
- PPNNE continued internal equity and anti-racism work with the hire of a Director of Diversity, Equity, Inclusion (DEI) and Workplace Culture who works across programs to expand and focus our efforts to serve all patients in our service areas equitably and to deconstruct institutional systems and culture in the service of patients, staff, and communities. This Director of DEI is actively consulting with our IBHSW WHI team on our model and approach to providing CHT services equitably in our health center regions.
- IBHSW team developed innovative clinical model and policy guidance to ensure clinical focus on WHI outcomes priorities including screening, suicidality and depression intervention, SBIRT care, and meaningful SDOH care management, referral and follow-up support.
- Innovation in provision of sexual and reproductive health during COVID-19 pandemic included provision of telehealth services, growth of our contraceptives by mail program to include more contraceptive options, the addition of subcutaneous Depo Provera for patients to self-administer and maintenance of access to LARC insertion and removal in all Vermont health centers throughout the pandemic.
- Development of a telehealth-specific approach to universal education and screening for intimate partner violence. This approach was developed in order to maintain patient safety during telehealth visits and continues our approach to universal education and provision of resources related to intimate partner violence for all patients and not only those who screen positive.



Randolph Health Service Area

Program Manager: Patrick Clark

Randolph by the Numbers

10,233	Heath Service Area Total Population
7,048	Blueprint Practices Patient Attribution
2,028	Total Accountable Care Organization (ACO) patient attribution, including non-Blueprint
24.1%	% of Blueprint-Attributed attributed to ACO
5.2	Community Health Team staff full time equivalents (FTEs)
2.2	Spoke staff FTEs
0.5	Women's Health Initiative staff FTEs
11	Self-management workshops held
45	Self-management workshop graduates
872	Community Health Team encounters
80	Patients served in area Spokes (Medicaid only)

Randolph Community Health Team

Randolph Blueprint Practices Blueprint and ACO Participation

Parent Organization	Practice Site Name	ACO Participation				PCMH	WHI	Spoke
		Medicaid	Medicare	BCBSVT	MVP			
Independent Practice	South Royalton Health Center	X	-	X	X	X	-	-
Gifford Health Care Inc.	Bethel Health Center	X	-	-	X	X	-	-
Gifford Health Care Inc.	Chelsea Health Center	X	-	-	X	X	-	-
Gifford Health Care Inc.	Health Center at Berlin	X	-	-	X	X	X	-
Gifford Health Care Inc.	Ob/Gyn and Midwifery	X	-	-	X	-	X	-
Gifford Health Care Inc.	Primary Care	X	-	-	X	X	-	X
Gifford Health Care Inc.	Rochester Health Center	X	-	-	X	X	-	-
Community Health Centers of the Rutland Region	Castleton Family Medical Center	X	-	X	X	X	-	X
Clara Martin Center	Clara Martine Center-Randolph	-	-	-	-	-	-	X

Major 2020 Achievements

- Working in conjunction with our Gifford Emergency Department (ED), Gifford Addiction Medicine, and Turning Point, we were able to implement **Rapid Access to Medication-Assisted Treatment (RAM) and access to Peer Recovery Coaches** in our area. If someone arrives at the Gifford ED seeking treatment for a substance use disorder, they can begin Medication-Assisted Treatment during that ED visit and can be seen within 72 hours of the ED visit by Gifford Addiction Medicine. They can also be connected to a Peer Recovery Coach during that ED visit, who can then provide interim support along the way.
- **Telehealth became a primary focus and priority** as the COVID-19 pandemic hit in early 2020. In addition to telehealth offerings in our medical practices, we were able to offer virtual Medication-Assisted Treatment services, Health Coaching, Care Coordination, and Self-Management Programs. Our CHT and MAT Team staff members quickly adjusted to this new way of connecting with community members to ensure people continue to receive needed services. Our Self-Management Program facilitators reported higher participant numbers and completion rates with the virtual offerings in many instances.

Additional Featured Projects

- Food insecurity has been a major focus and concern during the COVID-19 pandemic. Gifford worked with the Vermont Foodbank, Randolph Food Shelf, Vermont Youth Conservation Corp, Everyone Eats, and others to **expand access to nutritious food in the local community**. Getting the word out about additional food resources is an ongoing effort, but we have been successful in working with community partners to identify and address needs as they arise.
- Gifford is participating in the statewide **Zero Suicide initiative** and has implemented the screening tools in our primary care practices, emergency department, and inpatient setting. Zero Suicide is a commitment to suicide prevention in health and mental health care systems. It involves the implementation of a set of evidence-based tools and strategies used in a strong pathway of care for people who are suicidal. When implemented effectively, Zero Suicide reduces suicide deaths. Routine audits are conducted to determine that screening is being conducted, and that appropriate follow-up care is being offered. We partner with community mental health agencies to ensure people have access to the appropriate level of treatment.

Rutland Health Service Area

Program Manager: Kathy Boyd

Rutland by the Numbers

46,645	Heath Service Area Total Population
32,359	Blueprint Practices Patient Attribution
8,510	Total Accountable Care Organization (ACO) patient attribution, including non-Blueprint
23.5%	% of Blueprint-Attributed attributed to ACO
15.1	Community Health Team staff full time equivalents (FTEs)
25.8	Spoke staff FTEs
3	Women's Health Initiative staff FTEs
4	Self-management workshops held
35	Self-management workshop graduates
4414	Community Health Team encounters
413	Patients served in area Spokes (Medicaid only)

Rutland Community Health Team

Rutland Blueprint Practices Blueprint and ACO Participation

Parent Organization	Practice Site Name	ACO Participation				PCMH	WHI	Spoke
		Medicaid	Medicare	BCBSVT	MVP			
Independent Practice	Associates in Primary Care	-	-	-	-	X	-	-
Independent Practice	Marble Valley HealthWorks	-	-	-	-	X	-	-
Independent Practice	DRS Peter and Lisa Hogenkamp	X	-	-	X	X	-	-
Independent Practice	Jennifer Fauntleroy, MD	-	-	-	-	-	-	X
Community Health Centers of the Rutland Region (CHCRR)	Brandon Medical Center	X	-	X	X	X	-	X
CHCRR	Mettowee Valley Family Medical Center	X	-	X	X	X	-	-
CHCRR	Pediatric Associates	X	-	X	X	X	-	-
CHCRR	Rutland Community Health Center	X	-	X	X	X	-	X
CHCRR	Shorewell Community Health Center	X	-	X	X	X	-	-
CHCRR	Community Health Allen Pond	-	-	-	-	-	-	X
Rutland Regional Medical Center (RRMC)	Westridge Hub	X	-	X	X	-	-	X
RRMC	Rutland Women's Healthcare	X	-	X	X	-	X	-
Planned Parenthood of Northern New England	Rutland	X	X	X	X	-	X	-
Bradford Psychiatric Associates	Bradford Psychiatric Associates-Rutland	-	-	-	-	-	-	X

Major 2020 Achievements

The **response to COVID-19** has been far reaching, with the need for care coordination being more imperative than ever. The self-management program staff were redeployed to support the COVID-19 response effort, and additional CHT staff provided direct assistance in support of meal distribution efforts as well as provided support in surge preparedness efforts. The CHT remained active in its primary role to provide care coordination and overall support to patients, PCMHs and the Rutland community at large.

Additional Featured Projects

- The CHT is participating in a variety of Rutland based community initiatives, with a primary focus on SDOH. The CHT is working to assist with the anticipated **Bridge Housing Project**, a housing initiative led by the Rutland Housing Authority. Rutland community partners, including Rutland Mental Health and The Homeless Prevention Center and the Rutland Regional Medical Center will assist to provide housing support as well as navigation to services.
- The CHT facilitates a monthly **Referral and Care Coordination meeting**, which is attended by a variety of Rutland community stakeholders, including Rutland Mental Health, Bayada, Rutland VNA and Hospice of the Southwest Region, Community Health Centers, Voc Rehab, VCCI, SASH, Council On Aging, Homeless Prevention Center, BROC Community Action, and Rutland Regional Medical Center. The focus of this group is to facilitate education and awareness of community initiatives, improve collaboration and communication to avoid duplication of services, and streamline support of community members in the navigation of Rutland HSA services and systems.

- **Rapid Access to Medication** (RAM) is another highlighted success. West Ridge, Community Health Centers, Bradford Psychiatric Associates, and Rutland Regional Medical Center have been working collaboratively to support patients who present to the Emergency Department for opioid related issues. Rapid Access to MAT provides same-day treatment (where appropriate) with buprenorphine, a medication used to treat addiction and control withdrawal from opioids. The continued goals for this collaborative effort including providing medication in 3 days or less (from first point of contact to first medication dose), increase access by addressing real or perceived barriers and optimizing access points, and avoiding a gap in treatment between levels of care and provider transfers.

Springfield Health Service Area

Program Manager: Tom Dougherty

Springfield by the Numbers

21,724	Heath Service Area Total Population
12,127	Blueprint Practices Patient Attribution
4,977	Total Accountable Care Organization (ACO) patient attribution, including non-Blueprint
29.2%	% of Blueprint-Attributed attributed to ACO
13	Community Health Team staff full time equivalents (FTEs)
3	Spoke staff FTEs
0	Women's Health Initiative staff FTEs
9	Self-management workshops held
52	Self-management workshop graduates
2,678	Community Health Team encounters
160	Patients served in area Spokes (Medicaid only)

Springfield Community Health Team

Springfield Blueprint Practices Blueprint and ACO Participation

Parent Organization	Practice Site Name	ACO Participation				PCMH	WHI	Spoke
		Medicaid	Medicare	BCBSVT	MVP			
Springfield Medical Care Systems (SMC)	Charlestown Health Center	X	X	X	X	X	X	X
SMC	Ludlow Health Center	X	X	X	X	X	X	-
SMC	Mountain Valley Health Center	X	X	X	X	X	X	-
SMC	Rockingham Health Center	X	X	X	X	X	X	-
SMC	Springfield Community Health Center	X	X	X	X	X	X	-
SaVida	SaVida-Springfield	-	-	-	-	-	-	X

Major 2020 Achievements

Nothing among our achievements in 2020 can compare with the response of our staff and community partners to the unprecedented challenges of the COVID-19 pandemic arriving in March. Adaptability, resilience, creativity, and perseverance are all appropriate but inadequate terms to describe how **all levels of staff dealt with radical changes** that occurred in their personal and professional lives. This was certainly true of the CHT and care coordinators who quickly became adept at telehealth technology, assisted in a myriad of roles as needed by rapidly changing workflows at primary care practices and energetically reached out to patients facing the additional barriers of restricted access to essential services. As a result, it appears that access in many respects was enhanced for many patients. With the terrific collaboration of community partners and state agencies and the influx of new resources and funding, much of the worst of the pandemic's impact has been mitigated. Consequently, we can face the current surge with greater confidence and are better prepared for vaccine distribution as well. So many lessons were learned which will apply to meeting the needs of our community in a hopefully not-too-distant post-COVID-19 world.

Additional Featured Projects

- **Enhanced response to substance misuse.** Building on a strong network of substance use service providers including our local Turning Point Recovery Center, MAT Spoke practices, DA programs and CHT along with the Springfield Police Department, our community launched three new critical programs to expand and enhance access to substance use treatment and reduce opiate-related deaths: the Springfield Outreach Project (responding to opioid overdose calls with immediate follow up by recovery coaches and links to treatment), recovery coaches on call 24/7 in the emergency department, and Rapid Access to MAT in the emergency department.
- **Self-management goes virtual.** With COVID-19 shutting down in-person gatherings, our self-management programs quickly adapted to on-line and virtual learning platforms. Instructors adjusted to the new technology and found participants were open to new ways of learning and appreciated the removal of travel as a barrier, enabling greater access to programs whose distance was previously prohibitive. Contrary to expectations, programs were completed, and new opportunities identified to expand our offerings and their reach.

St. Albans Health Service Area

Program Manager: Denise Smith

St. Albans by the Numbers

33,328	Heath Service Area Total Population
23,323	Blueprint Practices Patient Attribution
8,997	Total Accountable Care Organization (ACO) patient attribution, including non-Blueprint
31.5%	% of Blueprint-Attributed attributed to ACO
15.9	Community Health Team staff full time equivalents (FTEs)
4.3	Spoke staff FTEs
1	Women's Health Initiative staff FTEs
3	Self-management workshops held
8	Self-management workshop graduates
17,000	Community Health Team encounters
334	Patients served in area Spokes (Medicaid only)

St. Albans Community Health Team

St Albans Blueprint Practices Blueprint and ACO Participation

Parent Organization	Practice Site Name	ACO Participation				PCMH	WHI	Spoke
		Medicaid	Medicare	BCBSVT	MVP			
BAART Programs	Northeast Hub	-	-	-	-	-	-	X
Independent Practice	Cold Hollow Family Practice	X	X	X	X	X	-	X
Primary Care Health Partners	St Albans Primary Care	X	X	X	X	X	-	-
Northern Tier Center for Health (NOTCH)	Alburg Health Center	X	X	X	X	X	-	-
NOTCH	Enosburg Health Center	X	X	X	X	X	-	-
NOTCH	Fairfax Health Center	X	X	X	X	X	-	-
NOTCH	Richford Health Center	X	X	X	X	X	-	-
NOTCH	St. Albans Health Center	X	X	X	X	X	-	-
NOTCH	Swanton Health Center	X	X	X	X	X	-	X
Northwestern Medical Center (NMC)	Northwestern Primary Care	X	X	X	X	X	-	-
NMC	Georgia Health Ctr	X	X	X	X	X	-	-
NMC	Northwestern OB/GYN	X	X	X	X	-	X	-
NMC	Pediatrics - Enosburg Falls	X	X	X	X	X	-	-
NMC	Pediatrics - Saint Albans	X	X	X	X	X	-	-
NMC	Michael Corrigan, MD	-	-	-	-	-	-	X
NMC	Emergency Department	-	-	-	-	-	-	X
Howard Center	St. Alban's Clinic	-	-	-	-	-	-	X

Major 2020 Achievements

We are pleased to report that despite the challenges of the pandemic, **each of our practices have or will achieve PCMH recognition**. The practices in the St. Albans health service area endorse the Patient-Centered Medical Home (PCMH) care model as it aligns with health reform, aiming at improving outcomes, reducing costs, and enhancing patient, provider, and staff satisfaction. The following practices achieved PCMH recognition in 2020: NOTCH—Fairfax Health Center, St. Albans Health Center, Swanton Health Center, Alburgh Health Center, Enosburg Health Center and Richford Health Center; Northwestern Medical Center Primary Care and Northwestern Medical Center Georgia Health Center; Northwestern Medical Center Pediatrics St. Albans and Northwestern Medical Center Pediatrics Enosburg; Cold Hollow Family Practice and St. Albans Primary Care. The practices have made the commitment to invest in the infrastructure needed to implement and sustain the type of changes necessary for improvements in quality, safety, efficiency, and cost containment.

We saw a 50% reduction in our MAT care team due to the closing of NMC's Addiction Services. However, this change opened the door for more providers to support our patients, and we welcomed increased **MAT services** from the Howard Center, the Phoenix House, and SaVida to our community. Franklin and Grand Isle residents have not been immune to the personal impacts of the COVID-19 pandemic. We have seen an increase in addiction, anxiety, and depression in our community members. The Screening, Brief Intervention, and Referral to Treatment (**SBIRT) screening** program at NMC's Emergency Department observed 50% of the patients screened were positive for anxiety during the summer months. The St. Albans Blueprint Community Health Team experienced many disruptions during the 2020 year due to the COVID-19 Pandemic. This resulted in displaced staffing and new opportunities to learn and implement **telehealth for care management and health services for mental health and substance use disorder needs.** The year 2020 also demonstrated how important the Blueprint program model is to provide continuous care to our patients, as funding remained constant during the pandemic due to the established value-based care model.

As with everywhere in Vermont there were significant efforts to keep our most vulnerable population safe and protected from COVID-19. The efforts to house people experiencing homelessness in hotels was a Herculean effort and the Community Health Team worked with our community partners to provide care management, access to primary care, and continued access to food and housing by supporting these community members while they were housed. During the early months of the pandemic some of the Community Health Team had to shift roles to support the COVID-19 response. Members of the team served to **support incident command structure and response**, front-line staff wellbeing, and direct patient care, screening, and triage. As the situation evolved into the fall months, RN care managers joined forces to support providers to obtain and document Clinician Orders for Life-Sustaining Treatment (COLST) forms in preparation for the influx of potentially critically ill patients. In addition, RN care managers and the Blueprint Program Manager were called upon to administer and **support local flu clinics**.

Our **Accountable Community for Health** (ACH) continues to work on joint initiatives to improve our quality metrics, transitions of care, and mental health and substance use disorder services. The Unified Community Collaborative (UCC) and Regional Clinical Performance Council (RCPC) have continued to meet throughout 2020 and have proven to be excellent forums for our community to discuss and address pressing and long-standing health concerns in our community related to social determinants, chronic disease management, quality metrics, and the costs of healthcare. RCPC committee work has also continued in our Care Coordination Sub-Committee, Mental Health Sub-Committee, and the Suicide Prevention Task Force.

Additional Featured Projects

- This past year we started a **learning collaborative focused on chronic pain and the impact of toxic stress and trauma** on the health of the body. This collaborative was one of the most well-attended and cross agency collaborations in our region. Unfortunately, we had to pause this work due to COVID-19, however we will be looking at ways to re-engage in 2021.
- This past fall, the CHT team was actively engaged in **flu vaccinations** throughout the region. Our FQHC stood up 16 school-based Flu clinics and worked with schools to provide the vaccinations to the children throughout the region. The FQHC also had 13 community-based vaccine clinics. NMC partnered with MVP health plan to offer 6 free flu clinics throughout Franklin County and focused on sites that support our most vulnerable populations. Our primary care groups got very creative in how they offer the flu shots and hosted multiple drive-up flu clinics and opportunities for their patients. The FQHC also employed a Mobile COVID testing team where we are in 5 towns 5 days a week.
- The **Women's Health Initiative** has new-found energy and is working diligently to screen, document, and track their work. This initiative will expand, as we welcome a part-time clinician to our Planned Parenthood site in St. Albans.
- Currently, there are various organizations participating in the **Asthma/COPD Learning Collaborative** offered through OneCare VT, and we are excited to see what comes of this opportunity for our region.
- The NCSS integrated mental health and substance use disorder social workers have **integrated evidenced based treatment models** into their workflows at each primary care practice including Cognitive Behavioral Therapy (CBT) for Insomnia, CBT for Chronic Pain, Acceptance and Commitment Therapy (ACT), CAMS, Motivational Interviewing, CBT, and Solution Focused treatment. They are also trained in the tenants of Dialectical Behavioral Therapy and the treatment of co-occurring mental health and substance use disorders.
- A few things we are looking forward to in 2021: The Zero Suicide Grant received by both NCSS and Cold Hollow Family Practice, more opportunities for self-management programming to be offered statewide via digital platforms, a renewed commitment to learning and growth around chronic pain, trauma, and resilience, and a COVID vaccine.

St. Johnsbury Health Service Area

Program Manager: Katie Bocchino

St. Johnsbury by the Numbers

20,250	Heath Service Area Total Population
13,277	Blueprint Practices Patient Attribution
3,962	Total Accountable Care Organization (ACO) patient attribution, including non-Blueprint
26.4%	% of Blueprint-Attributed attributed to ACO
18.8	Community Health Team staff full time equivalents (FTEs)
2	Spoke staff FTEs
0.75	Women's Health Initiative staff FTEs
12	Self-management workshops held
43	Self-management workshop graduates
16,206	Community Health Team encounters
76	Patients served in area Spokes (Medicaid only)

St. Johnsbury Community Health Team

St Johnsbury Blueprint Practices Blueprint and ACO Participation

Parent Organization	Practice Site Name	ACO Participation				PCMH	WHI	Spoke
		Medicaid	Medicare	BCBSVT	MVP			
BAART Programs	Northeast Hub	-	-	-	-	-	-	X
Northeastern Vermont Regional Hospital (NVRH)	Corner Medical	X	-	X	X	X	-	X
NVRH	Kingdom Internal Medicine	X	-	X	X	X	-	-
NVRH	St. Johnsbury Pediatrics	X	-	X	X	X	-	-
NVRH	Women's Wellness Center	X	-	X	X	-	X	-
Northern Counties Health Care (NCHC)	Concord Health Center	X	-	X	X	X	-	-
NCHC	Danville Health Center	X	-	X	X	X	X	X
NCHC	St. Johnsbury Family Health Center	X	-	X	X	X	X	X

Major 2020 Achievements

Caledonia/Southern Essex Community Response Team (CSERT). In early March 2020 at the start of the COVID-19 pandemic, Northeast Kingdom Community Action (NEKCA) established the CSERT to coordinate a community-wide response to the pandemic. Subcommittees were also formed to address housing, food insecurity, health and wellbeing, and communication. Representatives from community organizations throughout the St. Johnsbury HSA joined the CSERT, including but not limited to Northeastern Vermont Regional Hospital, Northern Counties Health Care, Caledonia Home Health Care and Hospice, EMS and Fire and Rescue, St. Johnsbury town manager, NEKCA, Vermont Food Bank, Rural Edge, Vermont Department of Health, Department of Corrections, School Superintendent and school leaders, Community Connections (CHT), Northeast Kingdom Human Services, NEK Council on Aging, and Community Justice Center.

CSERT discussions revolved around identifying immediate challenges faced by community members and brainstorming ideas for whether and how organizations could partner together to meet those needs. Response efforts adapted as needs changed. As individuals and families in our community faced new challenges due to COVID-19, the CSERT worked to help ensure organizations could partner together to meet the higher demand for needs like food and housing, and to ensure patients, especially older adults and people with underlying medical conditions who are at higher risk for COVID-19, continued to receive appropriate medical care. Strategies for supporting partner organization's efforts outside of the CSERT meetings were discussed, as well as resources, available grant funding, and consistent messaging about how to access available resources and how to stay safe and protected for our community.

The CSERT initially held virtual meetings for one hour twice a week and now meets virtually for one hour every two weeks. Although there were times when the meeting only had a few in attendance, the dedication to and pride for our community showed through with consistent participation and engagement within this collaborative effort. The silver lining of this essential engagement of emergency response has been our community's ability to strengthen and widen our core network of community partners, to engage strongly and collectively. Our community without a doubt built stronger partnerships.

The CSERT has grown to also become a support network for each other as community leaders. The team is currently engaged in trauma and resiliency work, as well as diversity, equity and inclusion work all aimed at supporting each other and our community through the next wave of this pandemic and to grow stronger community connections, together.

COVID-19 Response: Outreach and Patient Care

NVRH and NCHC worked diligently throughout the year implementing and adapting policies, protocols and workflows to continue to provide safe, timely and efficient care to our community during the pandemic.

NVRH:

Quickly implemented and staffed a "drive-thru" testing site and process for patients.

- Set up a public COVID-19 hotline.
- Regularly update our website with the most up-to-date information about COVID-19.
- Swiftly established a Respiratory Intensive Care Unit, and renovated some rooms in the ICU, Emergency Department, and Medical Surgical floor as well as in St. Johnsbury Pediatrics to be negative pressure rooms.
- Opened a Respiratory Care Clinic.
- Quickly established new cleaning and infection prevention protocols, which continue to be updated.
- Re-directed patients on how to get help while walk-ins were temporarily suspended. (Telehealth and how to schedule safe face-to-face visits)
- Develop care plans with patients who experience stress or difficulty during COVID-19. Help patients create personal goals around healthy lifestyle changes related to social distancing, personal hygiene and managing chronic diseases.
- Worked with self-management workshop leaders to provide virtual tobacco cessation, chronic disease, and diabetes prevention classes.
- Outreach to older adults and vulnerable populations at risk of food insecurity, lack of transportation, unsafe housing, access to primary care provider etc., and connect them to services.
- Care coordinators used EMR and ACO reports to reach out to patients to ask if they are experiencing any challenges related to food, housing, access to healthcare, transportation, income, parenting.

NCHC:

- Quickly spun up Respiratory Care Clinic for evaluation of symptomatic patients and/or patients with possible exposure.
- Developed myriad protocols and practice flows about who to see in-person vs. via telephone/telehealth, triage (testing vs. home, vs. Respiratory Care Clinic, vs. ED).
- Utilized Care Messenger program for scheduled text messages to patients to keep them informed.
- Changed 'on hold' music to informative messaging.
- Developed radio and newspaper ads to let folks know we are open and not to delay care.
- Sent telehealth patient experience survey to 600+ patients and received over 150 responses.
- Used multiple data sources (internal EHR information, COVID-19 risk info from ACO) to develop tiered outreach protocol and lists of patients (i.e., medical risk, mental health and substance use disorder risk, social risk, etc.) to contact.
- Quickly developed public-facing tools on our internet for patients to access telehealth and submit "needs" to our community resource coordinators.
- Switched to performing majority of immunizations and blood draws in vehicles.
- Switched our CDC/VDH 1815 grant focus to COVID-19 including outreach to patients identified as high risk (as mentioned above) and with HbA1c tests over 9% along with Diabetes and COVID-19 specific patient materials.

Additional Featured Projects

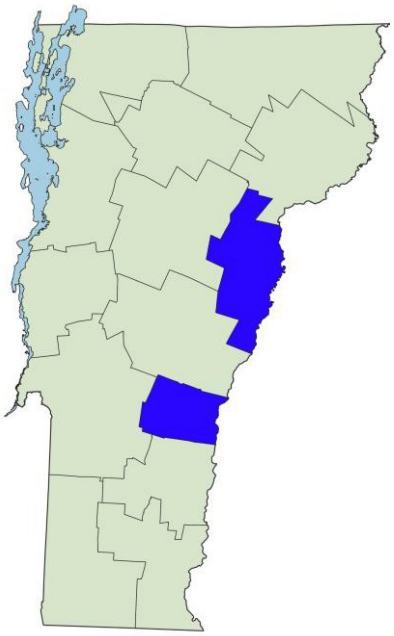
Telehealth implementation in response to COVID-19. In response to the pandemic and to comply with safety recommendations from the CDC, NVRH ambulatory practices quickly implemented a model of telehealth services in March 2020. Implementation of this model allowed the ambulatory practices to continue to provide routine care (wellness visits, medication consultations and mental health support) to their patients, to support patients experiencing acute illnesses, and for screening patients for COVID-19. Provider's schedules were adjusted to

accommodate a certain number of telehealth visits each day. Special telehealth templates were created for documentation completion for billing purposes. A telehealth visit type in 20- and 40-minute time slots was created for audio-only and for portal visits. Patients were encouraged to sign up for the patient portal for a telehealth visit, but if a patient did not have the appropriate technology or were unable to sign up for the portal, audio-only telephone visits were allowed between a patient and their provider.

Youth Leadership and Development. The YAC is back! NCHC and NVRH are two of eight YAC (Youth Advisory Council) steering committee organizations who have come together to revive this once powerful group of youth. The YAC is meant to be a group of youth leading themselves in engaging and meaningful community building. The YAC Steering Committee has developed a new mission statement and successfully recruited three YAC advisors who have gone on to engage several youths to form the initial group and start the work of identifying priorities, linking to other community-wide initiatives and planning events.

NEK Create Health. The NEK Council on Aging partnered with NCHC and Catamount Arts to identify joint patients/clients at risk of isolation – especially during the COVID-19 pandemic - to participate in the NEK Create Health program. This program provides art materials, journal prompts and weekly check-ins with a NCHC Community Resource Coordinator to support patients to chronicle and work through this experience, and then measure needs before, during, and after the project to demonstrate that art can be a successful intervention to address social isolation and despair. While recruitment proved challenging during the initial stay at home order, the program has since been extended successfully to members of the NCHC Walking for Wellness group who are excited to begin.

Suicide Prevention. Preventing suicide in the NEK is a priority identified by the NEK Prosper! Mentally Healthy Collaborative Action Network through data provided by the VT Suicide Prevention Data Workgroup and Youth Risk Behavior Survey. NCHC has been collaborating with multiple partners, most notably NKHS' Zero Suicide team to provide NCHC staff and community partners with training on how to identify and address suicidality. Training sessions have included single-day QPR (Question, Persuade, Refer) Gatekeeper Training and safe TALK (Suicide Alertness for Everyone) training and multi-month Collaborative Assessment and Management of Suicide (CAMS) training supported by a grant from the Vermont Department of Health through the Vermont Suicide Prevention Center. The CAMS framework is an internationally recognized evidence-based collaborative intervention for clients at risk for suicide. Several members of both the NKHS and NCHC staff are CAMS-trained graduates and learned how to use CAMS to assess, treat, and manage suicidality and are now part of the NEK CAMS-care Team. This team meets monthly to stay connected in their progress using CAMS-care, discuss clinical processes, and create community collaboration toward a culture of holistic care for those clients needing this support.



Windsor Health Service Area

Program Manager: Jill Lord

Windsor by the Numbers

33,034	Heath Service Area Total Population
13,277	Blueprint Practices Patient Attribution
5,650	Total Accountable Care Organization (ACO) patient attribution, including non-Blueprint
24.3%	% of Blueprint-Attributed attributed to ACO
10.2	Community Health Team staff full time equivalents (FTEs)
4.4	Spoke staff FTEs
0	Women's Health Initiative staff FTEs
9	Self-management workshops held
52	Self-management workshop graduates
n/a	Community Health Team encounters
237	Patients served in area Spokes (Medicaid only)

Windsor Community Health Team

Windsor Blueprint Practices Blueprint and ACO Participation

Parent Organization	Practice Site Name	ACO Participation				PCMH	WHI	Spoke
		Medicaid	Medicare	BCBSVT	MVP			
Habit OPCO	West Lebanon Hub	-	-	-	-	-	-	-
Independent Practice	Upper Valley Pediatrics; PLLC	X	-	X	X	X	-	-
Independent Practice	White River Family Practice	X	X	X	X	X	-	-
Independent Practice	Connecticut Valley Recovery Services	-	-	-	-	-	-	X
Little Rivers Health Care (LRHC)	Bradford	-	-	-	-	X	-	-
LRHC	East Corinth	-	-	-	-	X	-	-
LRHC	Wells River	-	-	-	-	X	-	X
Mt. Ascutney Hospital and Health Center (MAHHC)	Physician Practice	X	X	X	X	X	-	-
MAHHC	Ottauquechee Health Center	X	X	X	X	X	-	-
Bradford Psychiatric Associates	Bradford Psychiatric Associates-White River Junction	-	-	-	-	-	-	X

Major 2020 Achievements

- **Community Health Implementation Plan.** As a result of our community health needs assessment and as part of our Windsor Area Community Collaborative, an Accountable Community for Health, we developed 6 workgroups involving 99 community partners designed to improve the health and well- being of our community by addressing the following priority health needs: (1) Alcohol and Substance Misuse (2) Housing (3) Strengthening Families (4) Senior Health (5) Food Security and (6) Spiritual Health. Each of these workgroups analyzed and created problem statements, completed root cause analyses, developed aim statements, selected best practice strategies and delineated outcome evaluations utilizing results-based accountability. This grass roots community mobilizing is aimed at creating a collective impact approach to improving population health.
- We developed a community-wide multisectoral COVID-19 Windsor Area Response Team, to meet the needs of the community and address barriers created by the pandemic as follows:
    1. **Communication.** The purpose is to educate, share resources, promote health and reduce risk of infection, decrease social isolation, and promote compassionate support. These efforts included:
        - Created a web site for citizens to express needs and developed a workflow to meet the needs; to recruit support and mobilize community volunteers.
        - Disseminated daily education and resources through website, social media, front porch forum, town newsletter, electronic distribution networks.
        - Developed a system of street captains for local communication network.
        - Developed a compassionate support outreach of phone calls and pen pals to all local nursing homes and assisted living as well as elders and socially isolated individuals.

2. **Food.** Decrease risk of food insecurity and hunger in a time of crisis.
3. **Economic Support.**
    - Developed an algorithm linking financial needs with traditional resources, such as Economic Services and SEVCA and then to grant resources.
    - Worked with Dartmouth Hitchcock Medical Center $20,000 grant, Woodstock Relief Fund $130,000+, Vermont Community Foundation, and Ottauquechee Health Center.
    - Mobilized the CHT social workers with Volunteers in Action and our Windsor Community Health Clinic (free clinic at MAHHC) to assess and meet the pressing needs for social determinants of health. We have used $20,000 to-date to assist individuals and families utilizing the DH COVID-19 grant.
4. **Child Care and Family Stress**. Assessed and responded to increase signs of distress/stress of families. Mt. Ascutney Hospital and Health Center (MAHHC) worked with Health Care and Rehabilitation Services (HCRS) to provide three Suicide Prevention web conferences to identify the signs for suicide risk, provided instruction on how to talk to someone about suicide, and how to get help for the person at risk.
5. Promotion of the warm line from HCRS for counseling support.

Additional Featured Projects

Unfortunately, Windsor County has the highest opioid death rate since July 2020. We have mobilized multifactorial community partners in a prevention and harm reduction effort. Our work on the **prevention of opioid related deaths** for our county can be summarized as follows:

- Rapid Access to MAT (RAM) induction in MAHHC ER with direct connection to Connecticut Valley Recovery Services for treatment.
- MAHHC ER continues to be a Narcan distribution site for the community.
- Connection with VA Rapid Access to Medication
- Led a coalition of MAHHC, VA and Springfield Hospital to assist in initiation of RAM in Springfield including sharing policies, procedures, and funding through the VDH Community Overdose to Action Grant. Springfield started this care in November 2020.
- Worked with the syringe service and Connecticut Valley Recovery Services to increase education and access to Narcan. We continue to work on an educational booklet that will take various formats depending on the audience. We have delivered a training webinar for Recovery Coaches and the Hartford Police Department so that they can better teach those who carry Narcan. We organized two additional webinars to target police and EMS and our general community partners and organized a 'Train the Trainer' program.
- Worked with Recovery Center Turning Points of Springfield and Wilder, HCRS, Police and Fire Departments of Windsor, Hartford and Springfield to replicate outreach after overdose initiated by police/fire and carried out by Recovery Coaches and HCRS. This effort provides a linkage to support, treatment and harm reduction after an overdose to the patient and their family.
- Worked with the Recovery Point Turning Center to link recovery coaches with those struggling from addiction in the emergency department and community wide.

The Windsor team has shared the following poem to conclude their report and reflect on the many challenges they and Vermonters have faced over the past year and the resiliency the community demonstrated.

Pandemic
A poem by Lynn Ungar

What if you thought of it
As the Jews consider the Sabbath– The most sacred of times?
Cease from travel.
Cease from buying and selling.
Give up, just for now, on trying to make the world
Different than it is.
Sing. Pray. Touch only those to whom you commit your life.
Center down.

And when your body has become still, reach out with your heart.
Know that we are connected
In ways that are terrifying and beautiful. (You can hardly deny it now.)
Know that our lives are in one another stance. (Surely, that has become clear.)
Do not reach out your hands.
Reach out your heart. Reach out your words.
Reach out all the tendrils of compassion that move, invisibly,
Where we cannot touch.

Promise this world your love– For better or for worse,
And sickness and in health,
So long as we all shall live.

Conclusion

Throughout its history, the Blueprint has supported health care reform from its earliest focus as a chronic care initiative to its current form supporting strong primary care and coordination of medical and social services across communities. The regional leaders in Blueprint's network have held key roles in facilitating local change and innovation while promoting national standards of care, contributing to the long-term success of the program. The HSAs At-a-Glance section highlights the work done at the local level to develop and maintain collaboration across community organizations and to facilitate change and innovation. Furthermore, with challenges brought by the COVID-19 pandemic, the Blueprint infrastructure and staff demonstrated resilience and an ability to adapt to rapidly changing health care and public health needs.

The Blueprint has also evolved with the changing landscape of health care reform. As the state continues to work to achieve its health care reform targets for cost containment and access to and quality of care, the health care elements established and supported by the Blueprint provide an important foundation for future efforts in health care reform, including the coordination of services provided by primary care, hospitals, medical specialists, and community-based organizations as envisioned in the Vermont All-Payer ACO Model Agreement.