# BLUEPRINT FOR HEALTH

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# AGENCY OF HUMAN SERVICES

*The AHS Central Office, or*
*"The Secretary's Office"*

Lead by Jenney Samuelson, Secretary of the Agency of Human Services

Responsible for establishing and supporting the administration of policy, practice, fiscal, and operations across the Departments and District Offices

Ensures holistic, consistent, and reliable service delivery to Vermonters.

# BLUEPRINT FOR HEALTH CENTRAL OFFICE STAFF

## WATERBURY, VERMONT

**DR. JOHN SAROYAN**
Executive Director

**JULIE PARKER**
Assistant Director

**MARA KRAUSE DONOHUE**
Assistant Director

**VACANT**
Project Administrator

**ERIN JUST**
Health Services Researcher

**TIM TREMBLAY**
Data Analytics and Info Administrator

**CALEB DENTON**
Data Analytics and Info Administrator

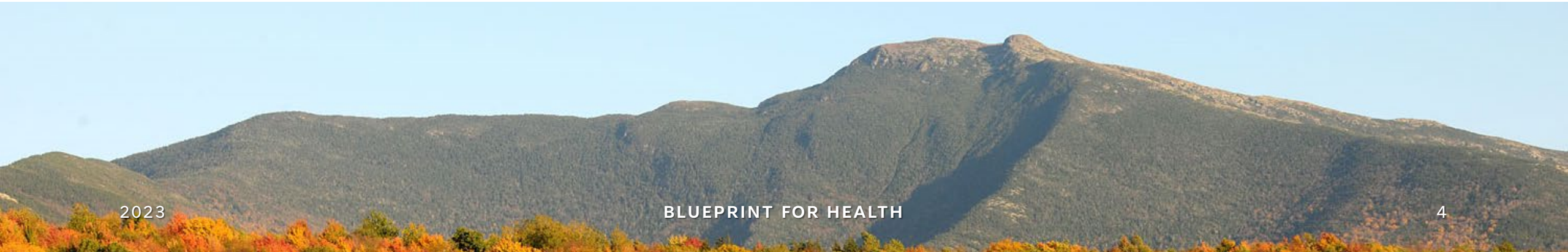
**JENNIFER HERWOOD**
Payment Operations Administrator

**AVERIEL HOSSLEY**
Administrative Assistant

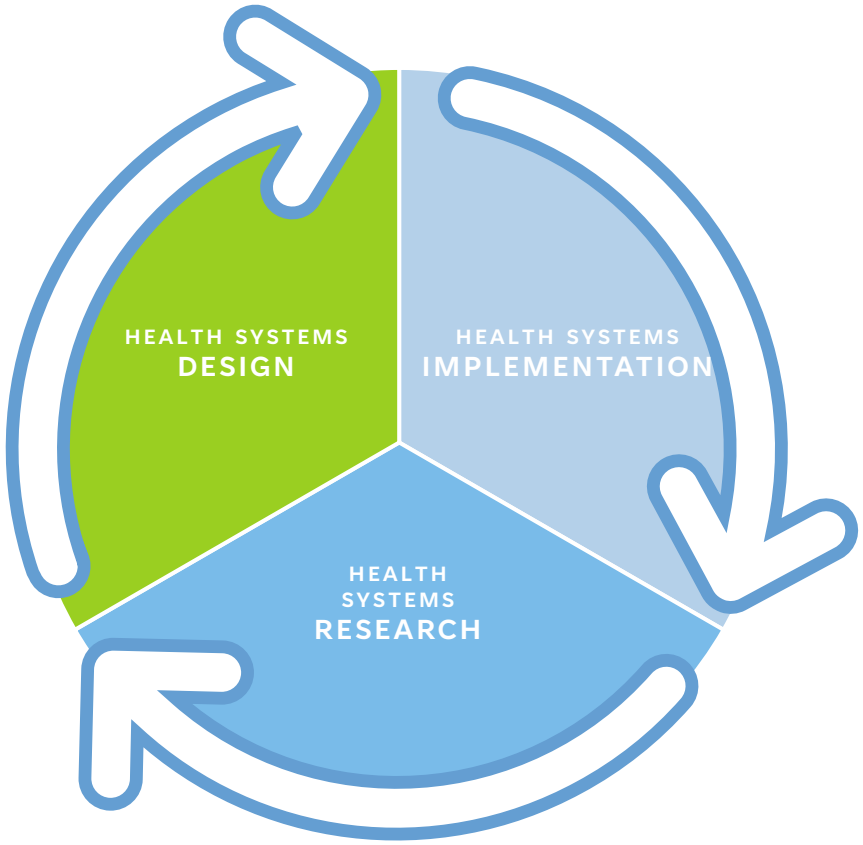
**ACT 128**

*"integrating a system of health care for patients, improving the health of the overall population, and improving control over health care costs by promoting health maintenance, prevention, and care coordination and management."*

2010 Vermont Statutory Framework
Act 128 Mission of Blueprint For Health



# BLUEPRINT FOUNDATION




## DESIGN

Incorporate the innovation cycle - *design, implementation, and research* - into all initiatives and services

## IMPLEMENTATION

Establish & sustain a network that can systematically test and implement innovative community-led strategies for improving health and well-being

## RESEARCH

Rapidly respond to Vermont's health and social service priorities through statewide implementation of new initiatives and service models

# THE BLUEPRINT MODEL

## IMPROVE POPULATION HEALTH

- Screening for Social Determinants of Health
- Support patient to manage Chronic Health Conditions

## ENHANCE PATIENT EXPERIENCE

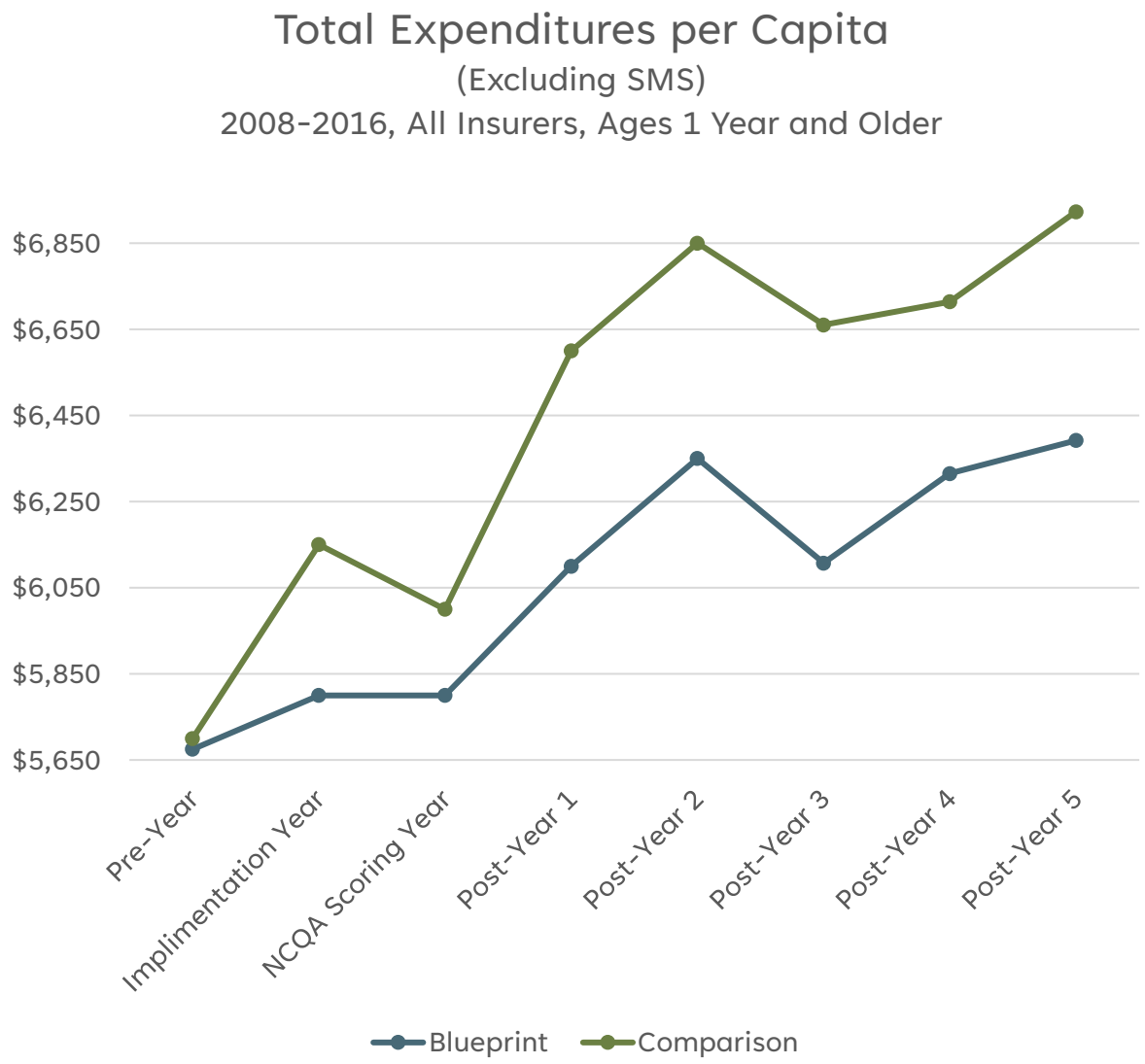
- Improve quality of care
- Ease access
- Reduce cost

# BLUEPRINT-ASSOCIATED COST-SAVINGS

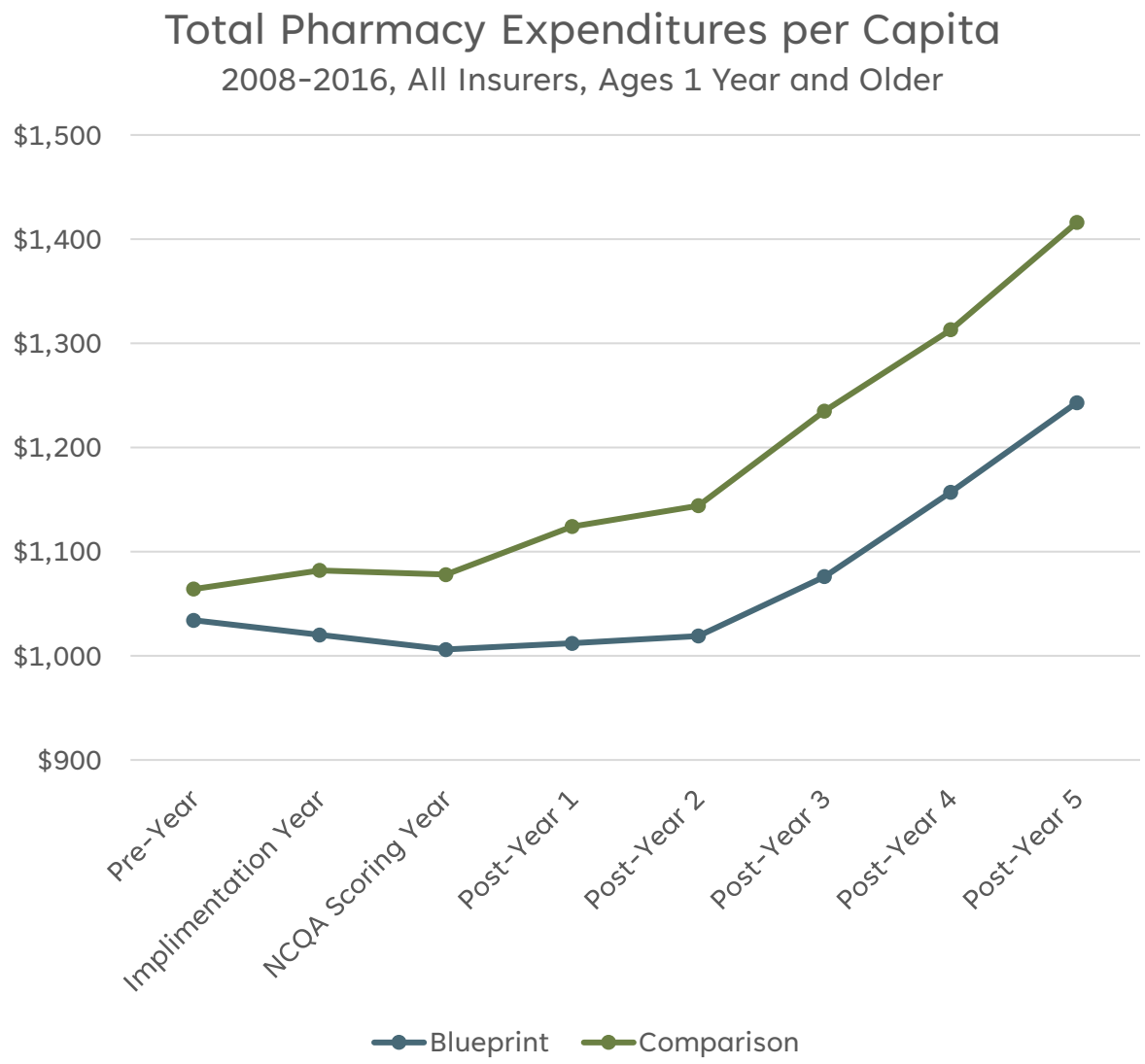
The 2017 Multi-Payer Advanced Primary Care Practice (MAPCP) Demonstration report revealed significant cost savings from Blueprint for Health programming (patient-centered medical homes, community health teams, and support and services at home) across 14 quarters

Data published by Jones et al in 2016 identified significant cost savings associated with Blueprint participation over a 6-year period

A


Total Expenditures per Capita
(Excluding SMS)
2008-2016, All Insurers, Ages 1 Year and Older
$6,850
$6,650
$6,450
$6,250
$6,050
$5,850
$5,650
Pre-Year
Implimentation Year
NCQA Scoring Year
Post-Year 1
Post-Year 2
Post-Year 3
Post-Year 4
Post-Year 5
Blueprint
Comparison

B


Total Pharmacy Expenditures per Capita
2008-2016, All Insurers, Ages 1 Year and Older
$1,500
$1,400
$1,300
$1,200
$1,100
$1,000
$900
Pre-Year
Implimentation Year
NCQA Scoring Year
Post-Year 1
Post-Year 2
Post-Year 3
Post-Year 4
Post-Year 5
Blueprint
Comparison

# BLUEPRINT-ASSOCIATED OUTCOME IMPROVEMENTS

In a 2014 mixed methods evaluation by the Centers for Disease Control and Prevention (CDC), the community health team (CHT) model in St. Johnsbury, Vermont was associated with:

- Increased efficiency within primary care
- Improved patient wellbeing
- Increased patient adherence to treatment and attention to health

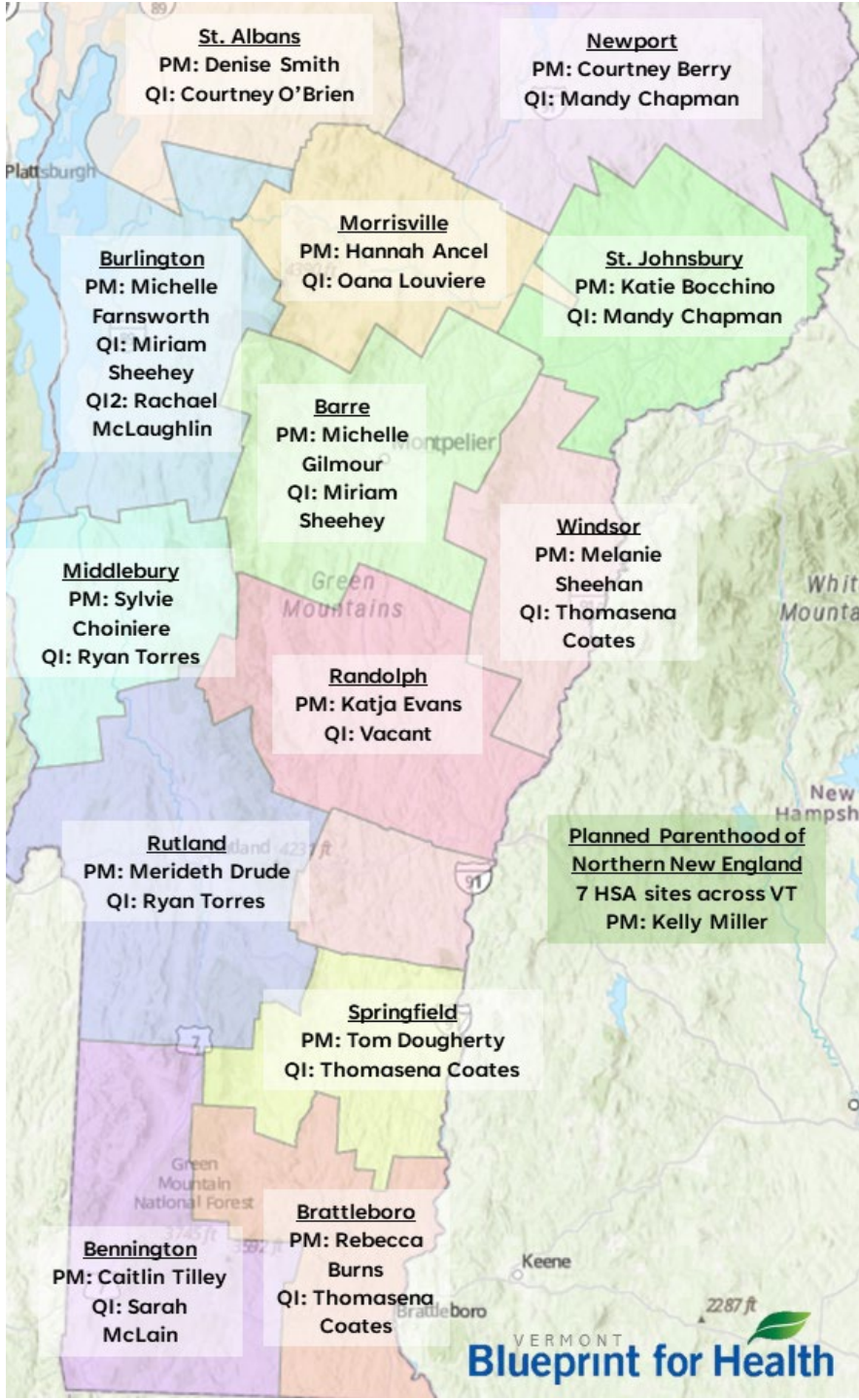
# HEALTH SERVICE AREAS

## EACH ADMINISTRATIVE ENTITY…

- is accountable for leading implementation and ongoing operations of the All-Payer Model (APM) and the Blueprint program in their HSA
- will receive multi-insurer payments to support hiring of Community Health Teams
- must be Centers for Medicare and Medicaid Services (CMS) eligible providers

## COMMUNITY HEALTH TEAM LEADS

- 13 Program Managers
- Quality Improvement Facilitators



# BLUEPRINT EXECUTIVE COMMITTEE

**PROVIDE**
high-level multi-stakeholder guidance on complex issues

**ADVISE**
the Blueprint Director on strategic planning and implementation of health services with an emphasis on prevention

**REPRESENT**
a broad range of stakeholders

(health services, insurers, professional organizations, community & nonprofit groups, consumers, businesses, and state & local government)

**COMMITTEE MAKEUP**
AHS Members, Commissioner of MH, Private Health Insurers, Home Health, Self-Insured Employers, etc...

Full list available in Blueprint Manual

# HEALTH SERVICE AREA PROGRAM MANAGER

**FUNDED BY**

annual grant signed for salary of a Quality Improvement Facilitator (in some HSAs)

**REPORTS**

primarily responsible for data collection, entry and completion

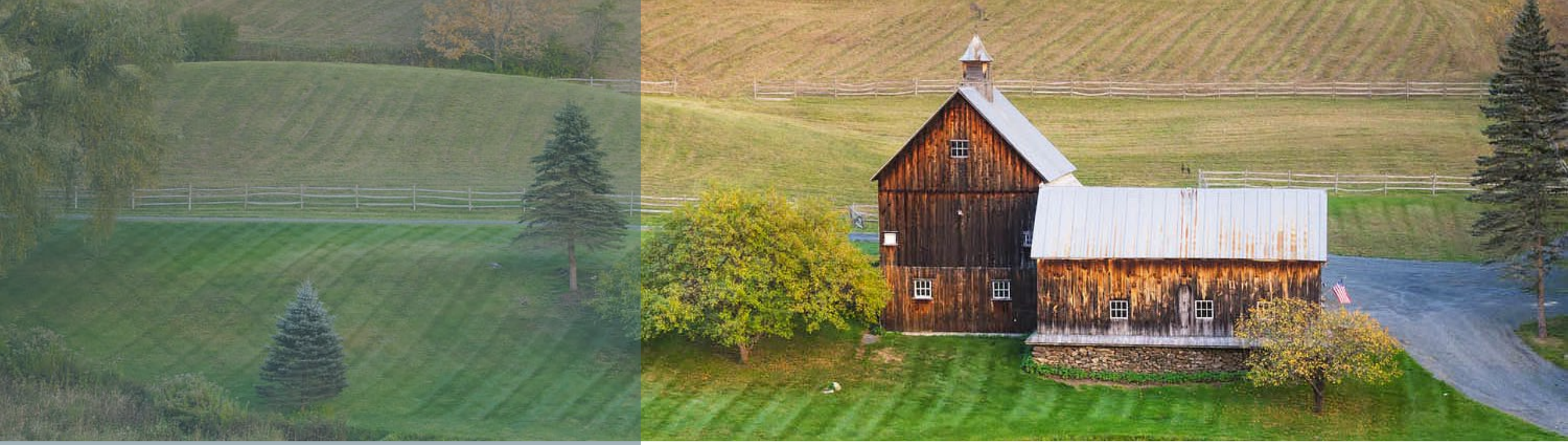
**OVERSIGHT**

administers CHT funds/staffing

**COMMUNITY**

collaborates and assists staff of PCMHs within the Health Service Area

Monthly invoices per contract sent to:
AHS.DVHAInvoices@vermont.gov



# BLUEPRINT PROGRAMS

- Patient-Centered Medical Homes
- Community Health Teams
- Hub & Spoke system of Opioid Use Disorder Treatment
- Pregnancy Intention Initiative

- Population data & analytics for policy makers and communities

# PATIENT CENTERED MEDICAL HOMES (PCMH)

**ACTIVE ENGAGEMENT**

Practices/Organizations annually pay a fee and register in a system called Q-PASS

**NATIONAL STANDARDS**

Must achieve and sustain recognition as a PCMH from the National Committee on Quality Assurance (NCQA)

Copy of Standards: http://www.ncqa.org

**"KM"**

Knowing and Managing Patients

**"AC"**

Patient Centered Access & Community

**"CM"**

Care Management and Support

**"CC"**

Care Coordination and Care Transition

**"QI"**

Quality Improvement & Performance Management

# QUALITY IMPROVEMENT FACILITATOR

## IMPROVE

- practice transformation as a Patient Centered Medical Home
- population health quality and payment reform efforts
- clinical, cost, or patient experience priorities identified by the practice

## PROMOTE

Team Based Care

## BASE PAYMENT

| | |
|---|---|
| $3.00 | Commercial |
| $4.65 | Medicaid |
| $2.05 | Medicare |

PAID BY COMMERCIAL AND MEDICAID

## PATIENT HEALTH CARE UTILIZATION – PRACTICE

PERFORMANCE PAYMENT

**UP TO $0.25**

Captures the number of services and their relative weight based on resources using their Resource Use Index (RUI) score, without price variation

PAID BY COMMERCIAL AND MEDICAID

## QUALITY MEASURE OUTCOMES – COMMUNITY & HSA

PERFORMANCE PAYMENT

**UP TO $0.25**

Measures affected by community, social, and environmental factors

- % of adolescents with an annual well-care visit (HEDIS AWC);
- % of children up to 3 years of age who have had a developmental screening (NQF 1448);
- % of individuals with hypertension in control (NQF 0018);
- % of individuals with diabetes in poor control (HgA1c > 9) (NQF 0059).

# PCMH PAYMENTS

## PER MEMBER PER MONTH (PMPM)

# PCMH AFFILIATION TYPE

| AFFILIATION TYPE | BP PRACTICE COUNT |
|---|---|
| FQHC-Owned | 47 |
| Hospital-Owned | 42 |
| Independent Multi-Site | 15 |
| Independent Single-Site | 30 |
| **Grand Total** | **134** |

CASE STUDY

# BLUEPRINT PATIENT CENTERED MEDICAL HOME MONTHLY PAYMENTS PAID TO THE PRACTICE

| PAYER | ATTRIBUTED PATIENT POPULATION PROVIDED BY PAYERS | PCMH PRACTICE BASE PAYMENT RATE (PER PATIENT PER MONTH) | PCMH PRACTICE PERFORMANCE PAYMENT RATE (PER PATIENT PER MONTH) | TOTAL PAID TO PRACTICE |
|---|---|---|---|---|
| Commercial Insurers CIGNA | 20 | $3.00 | $0.32 | $66.40 |
| Commercial Insurers BCBS | 400 | $3.00 | $0.32 | $1,328.00 |
| Commercial Insurers MVP | 60 | $3.00 | $0.32 | $199.20 |
| Medicaid | 800 | $4.65 | $0.32 | $3,976.00 |
| Medicare | 1020 | $2.05 | $0.00 | $2,091.00 |
| **Monthly Total** | **2300** | | | **$7,660.60** |

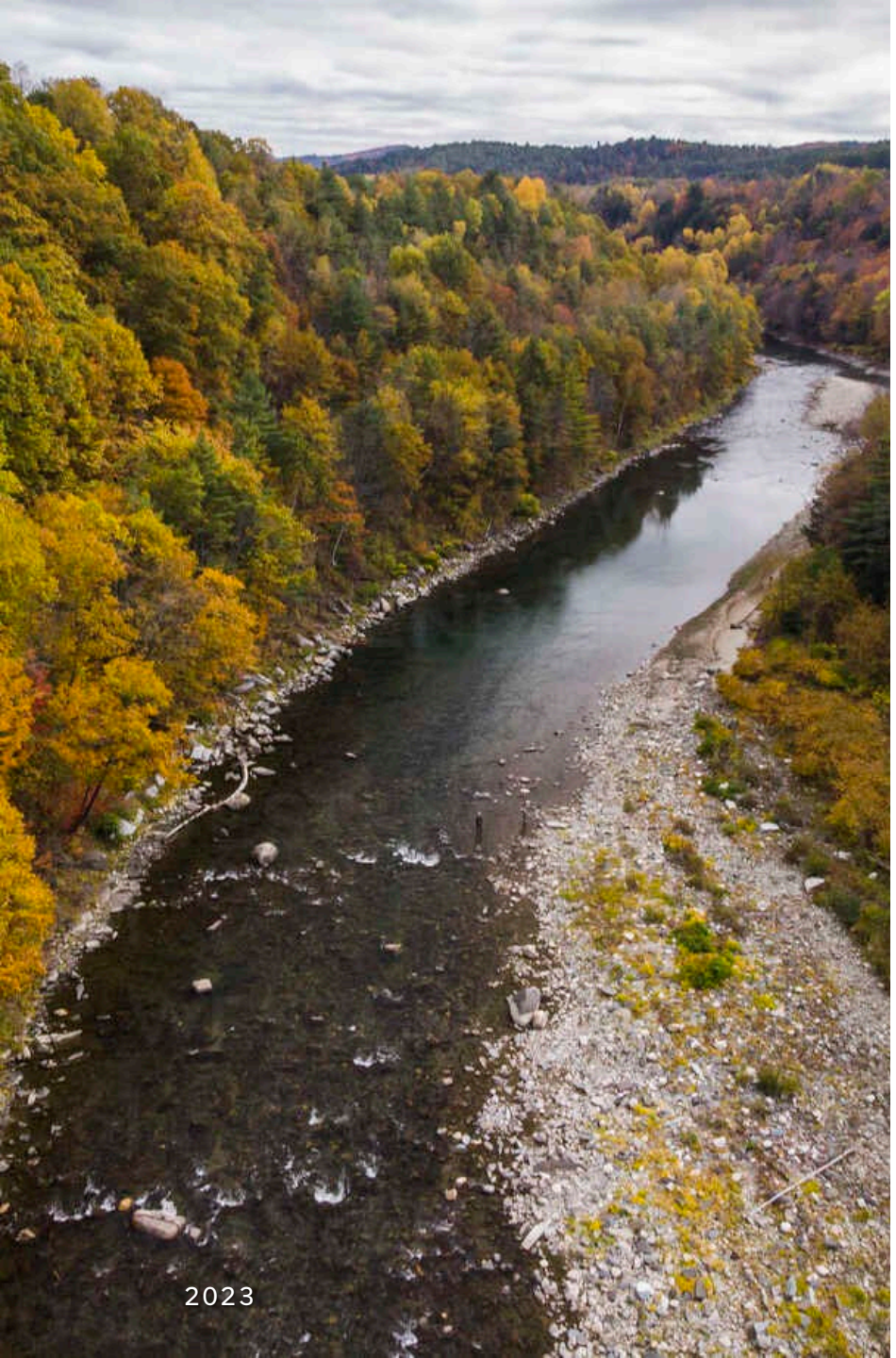
# COMMUNITY HEALTH TEAM

## SUPPORT PRIMARY CARE PROVIDERS

- identifying root causes of health problems
- including mental health
- screening for social determinants of health

## CONNECT PATIENTS

- effective interventions
- support to manage chronic conditions
- provide additional opportunities to support improved well-being by engaging in team care




# FUNDED COMMUNITY HEALTH TEAM

- NURSES
- MENTAL HEALTH CLINICIANS
- CASE MANAGERS
- CARE COORDINATORS
- PANEL MANAGERS
- DIETICIANS
- COMMUNITY HEALTH WORKERS

# COMMUNITY IS A WHOLE HEALTH TEAM

HOME HEALTH

PEERS

FOOD SHELF

DESIGNATED AGENCIES

AND MANY MORE...

HOUSING

CHRONIC CARE

HEALTH SERVICE AREAS RECEIVE FUNDS FROM INSURERS FOR STAFFING A

## COMMUNITY HEALTH TEAM

CHT Capacity Investment aids Vermonters

- greater access
- multi-disciplinary
- medical and social services

## PER MEMBER PER MONTH

| | |
|---|---|
| $2.77 | Commercial |
| $2.77 | Medicaid |
| $2.51 | Medicare |

CHT

## STAFFING MODELS

- Money for hiring staff sent directly to practices through Administrative Entity

**OR**

- or contract with another entity such as local Designated Agency

## CHT PAYMENTS:

PRIMARY CHT STAFF

MOUD CHT STAFF

WHI CHT STAFF

# CHT PAYMENT STRUCTURE

CASE STUDY

# BLUEPRINT CORE COMMUNITY HEALTH TEAM QUARTERLY PAYMENTS MADE TO THE ADMINISTRATIVE ENTITY

| PAYER | ATTRIBUTED PATIENT POPULATION PROVIDED BY PAYERS | COMMUNITY HEALTH TEAM STAFFING PAYMENT RATE (PER PATIENT PER MONTH) | TOTAL PAID TO ADMIN ENTITY |
|---|---|---|---|
| Commercial Insurers CIGNA | 65 | $2.77 | $544.00 |
| Commercial Insurers BCBS | 4064 | $2.77 | $33,774.92 |
| Commercial Insurers MVP | 689 | $2.77 | $5,725.74 |
| Medicaid | 4,340 | $2.77 | $36,066.36 |
| Medicare | 3,708 | $2.53 (+$0.25 to risk-bearing providers in the Medicare ACO) | $30,954.00 |
| **Monthly Total** | **12,866** | | **$107,065.02** |

# HUB AND SPOKE

## MEDICATION FOR OPIOID USE DISORDER (MOUD)

- supporting people in recovery from opioid use disorder
- **very effective treatment** for most people

Two settings for MOUD designated by Federal Regulations

- Opioid Treatment Programs (OTPs)
- Office Based Opioid Treatment (OBOT)

# HUB AND SPOKE PROGRAM

EST. 2013

## HUBS

9 PROGRAM SITES

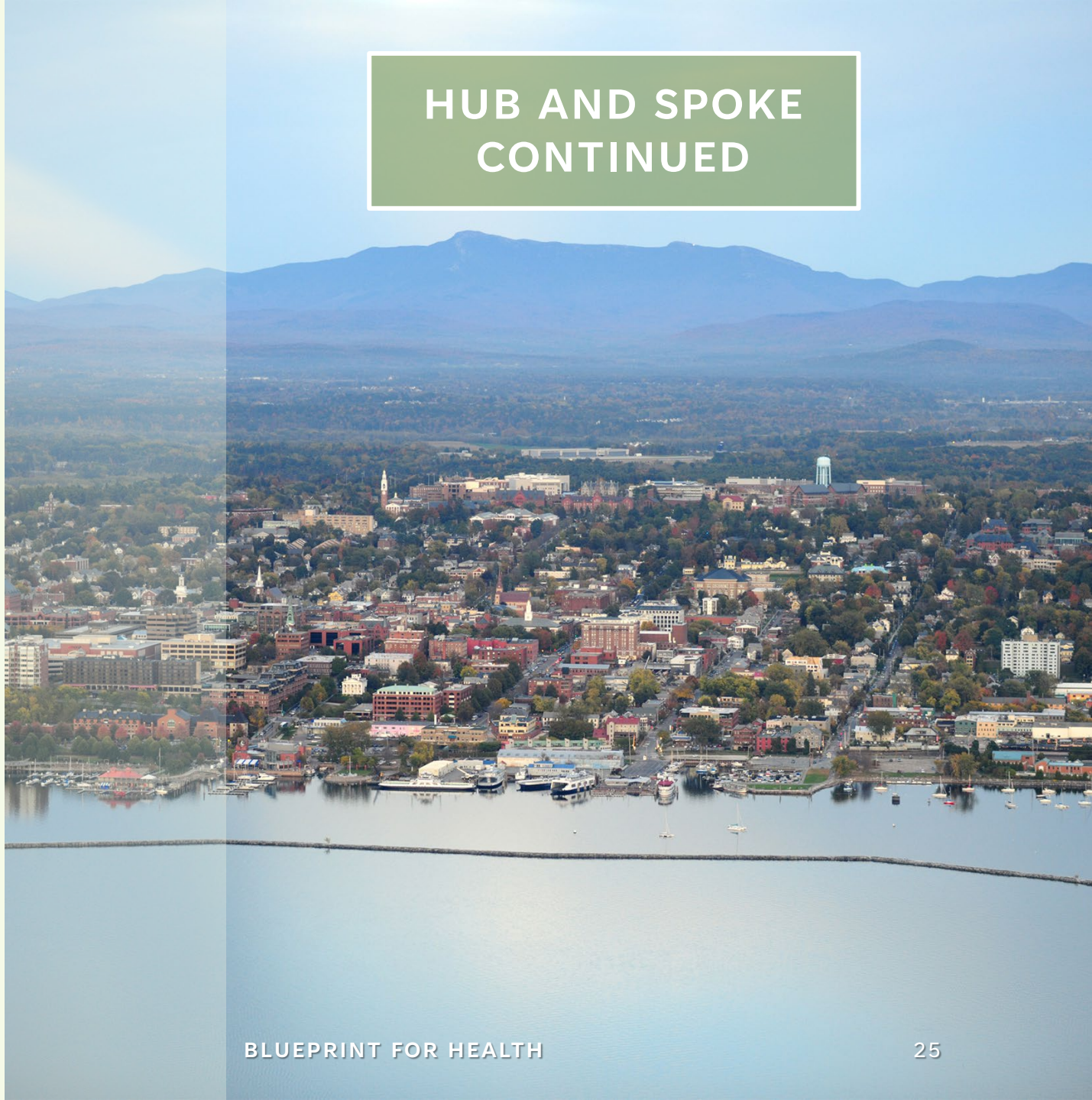
- Enhanced OTPs (Opioid Treatment Programs)
- Dispense Buprenorphine & Vivitrol addition to Methadone
- Augment staffing for health home services (care managers, counselors, nurses, and psychiatry)
- Monthly bundled rate

## SPOKES

113 PROGRAM SITES

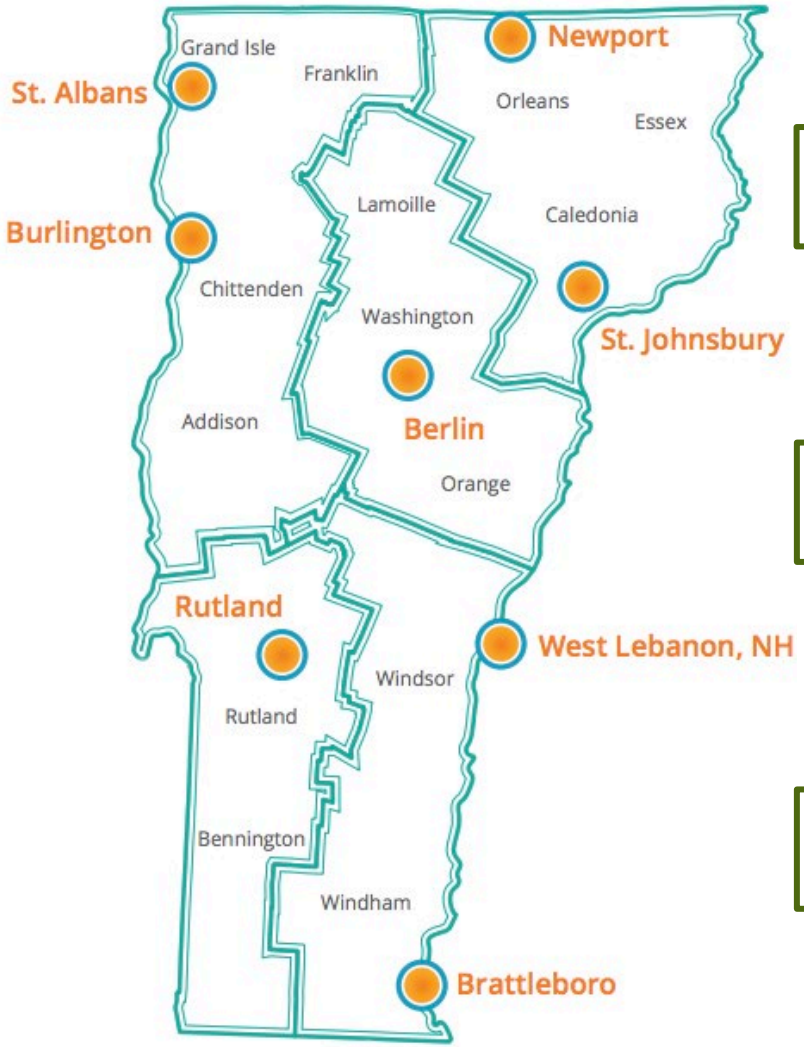
- Enhanced OBOTs (Office Based Opioid Treatment)
- 1 FTE RN & 1 FTE Licensed Addictions/Mental Health Counselor for 100 Medicaid Members provide health home services. (Claims based on Buprenorphine/Vivitrol)
- Hired and deployed as part of Blueprint CHT though the administrative entity

- Patients move between Hubs and Spokes based on their clinical needs
- Hubs and Spokes provide mutual support in conjunction with PCP
- RAM (Rapid Access to Medication)



# HUB AND SPOKE CONTINUED

# MEDICATION FOR OPIOID USE DISORDER
## IN VERMONT SPOKES




2023

Spoke Medicaid Patients Served

1,837 → 4,074

2013 Q1 — 2022 Q2

Spoke MOUD Prescribers

114 → 294

2013 Q1 — 2022 Q2

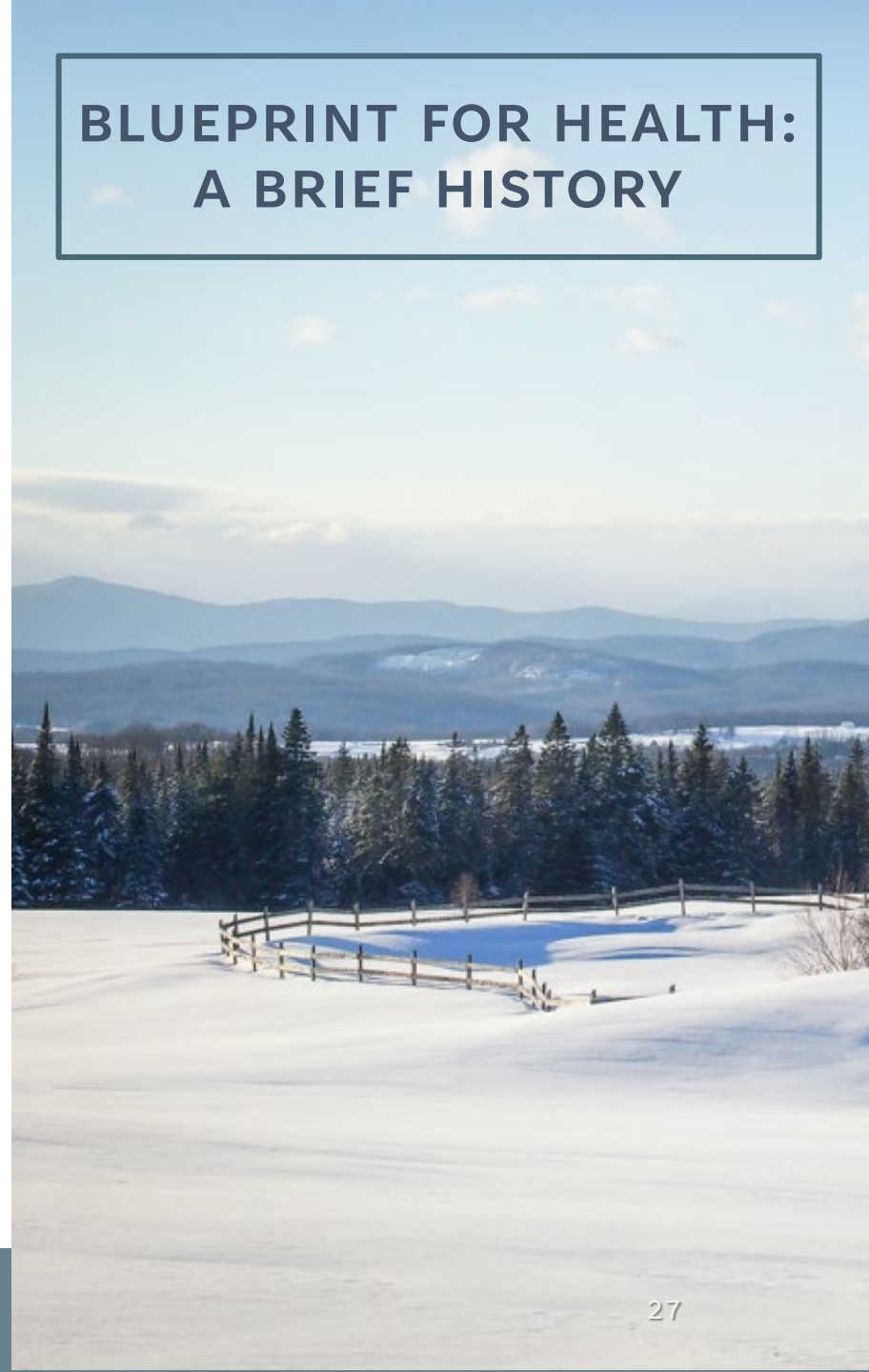
Spoke MOUD FTE Hired

7.6 → 78.85

2013 Q1 — 2022 Q2

# BLUEPRINT FOR HEALTH: A BRIEF HISTORY

| | |
|---|---|
| 2006 | Blueprint for Health codified into Vermont statute |
| 2007 | ACT 71 establishes Medical Home and Community Health Teams |
| 2008 | First pilot site: St. Johnsbury HSA |
| 2010 | Act 128 shifts the Blueprint from a pilot to a statewide program |
| 2011 | Vermont is one of the eight states selected for CMS' MultiPayer Advanced Primary Care Practice Demonstration |
| 2013 | Hub and Spoke program for Opioid Treatment and Office Based Opioid Treatment |
| 2017 | Pregnancy Intention Initiative/Women's Health Initiative/WHI |
| 2022 | Act 167 Requires recommendation on the amount to increase commercial insurer and Medicaid Contributions to Community Health Teams and Quality Improvement Facilitation |

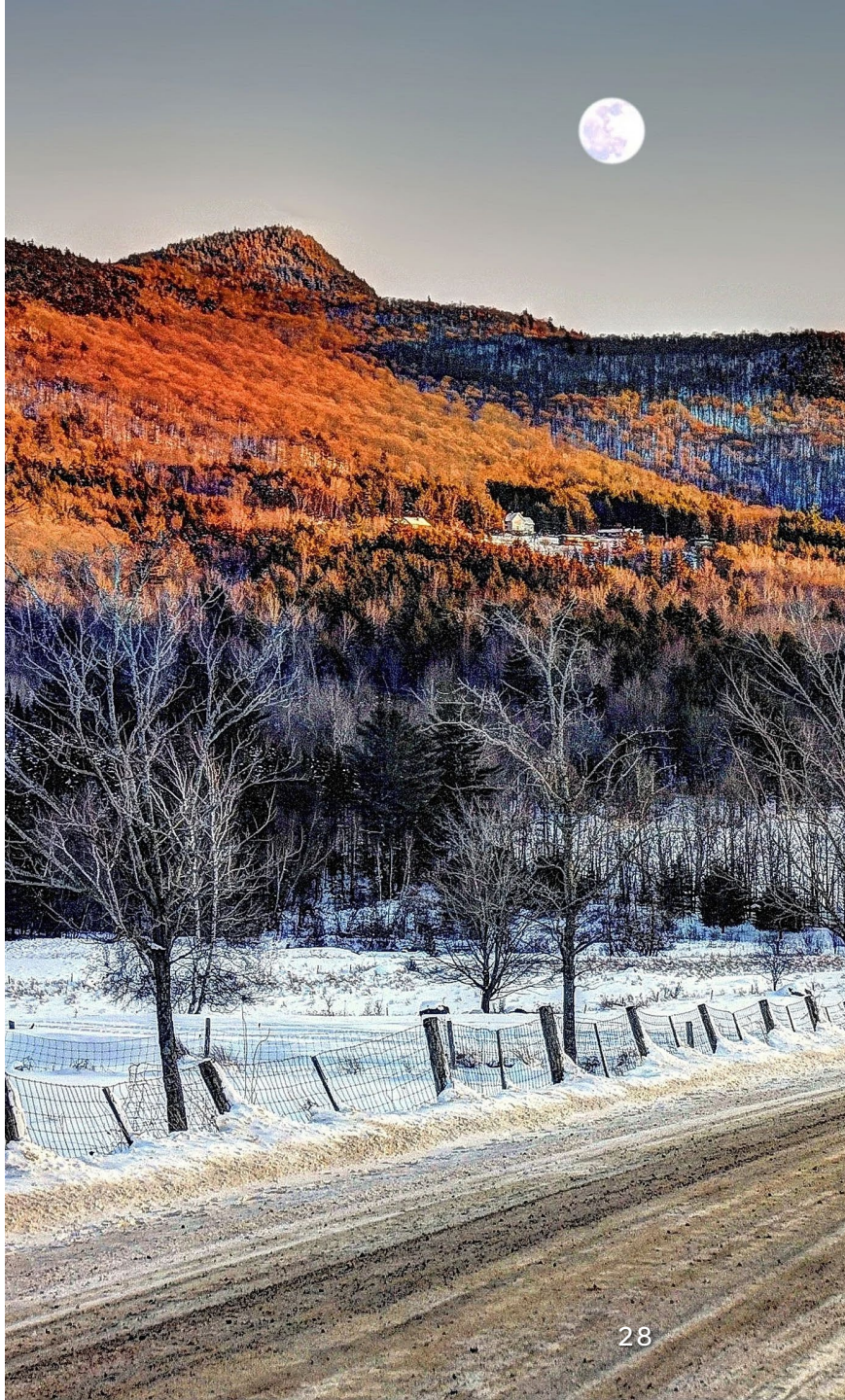


# PARTICIPATING PRACTICES (WOMEN'S HEALTH SPECIALTY IN BLUE)

## PREGNANCY INTENTION

| | |
|---|---|
| Barre | - CVMC Women's Health<br>- PPNNE<br>- UVMMC Berlin |
| Bennington | - SVMC OB/GYN<br>- Brookside Pediatrics & Adolescent Medicine<br>- Avery Wood |
| Brattleboro | - Four Seasons OB/Gyn Midwifery<br>- PPNNE |
| Burlington | - UVMMC Obstetrics and Midwifery<br>- Champlain Obstetrics and Gynecology<br>- PPNNE<br>- CHCB (4 sites)<br>- UVMMC Family Med (4 sites)<br>- Champlain Center for Natural Medicine |
| Middlebury | - UVM Porter Medical Center |
| Morrisville | - The Women's Center<br>- Hardwick Health Center<br>- Lamoille Health Family Medicine (2 sites – Morrisville & Stowe) |

| | |
|---|---|
| Newport | - North Country OB/GYN |
| Randolph | - Gifford Health at Berlin<br>- Gifford OB/GYN and Midwifery |
| Rutland | - Rutland Women's Health Care<br>- PPNNE |
| Springfield | - Rockingham Health Center<br>- Charlestown Family<br>- Springfield Community Health Center<br>- Ludlow Health Center<br>- Mountain Valley |
| St. Johnsbury | - Danville Health Center<br>- St. J Family Health Center<br>- Women's Wellness Center<br>- PPNNE |
| Windsor | - Little Rivers |
| White River Junction | - PPNNE |
| Williston | - PPNNE |



# RESOURCES

Blueprint for Health Manual and Implementation
https://blueprintforhealth.vermont.gov/implementation-materials

Blueprint Website
https://blueprintforhealth.vermont.gov/

Pregnancy Intention
https://blueprintforhealth.vermont.gov/sites/bfh/files/doc_library/WHIGuidedraft_4.21.21_0.pdf

Hub and Spoke Manual
https://blueprintforhealth.vermont.gov/sites/bfh/files/doc_library/SpokeGuide5172021.pdf

# RESEARCH AND EVALUATION

## Community Profiles

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

## Practice-Level Analyses

## WHI Evaluation

https://blueprintforhealth.vermont.gov/womens-health-initiative-profiles

## H&S/MAT Evaluation/Profiles

https://blueprintforhealth.vermont.gov/hub-and-spoke-profiles ;
https://blueprintforhealth.vermont.gov/reports-and-articles/journal-articles

## Annual Report

https://blueprintforhealth.vermont.gov/annual-reports

# THANK YOU

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