Community Health Team Expansion
July 2023-June 2024 Practice Attestation

I attest that is a Vermont Blueprint for Health Patient-Centered Medical Home (PCMH).

Street Address:

City, State, ZIP Code:

Office Telephone:

Primary Contact Name and Title:

Primary Contact E-Mail Address:

Goal of Blueprint CHT Expansion:

Vermont is experiencing increased deaths from drug overdose and suicide and concerning levels and acuity of mental health and substance use disorders. There is a need to broaden screening for and addressing social determinants of health, mental health and substance use disorders. The objective of this project is to ensure that screening, brief intervention, and navigation to services occurs across the entire population served by Blueprint primary care practices that are patient centered medical homes.

Practice Commitment

By accepting staffing or funds under the Blueprint Expansion Pilot, the Practice agrees to:

- Incorporate the Community Health Team (CHT) member into the patient's care team in support of expansion goals and strategies. CHT members will be embedded and integrated in the practice to the greatest extent possible for screening, assessment, intervention, and management of care interventions related to mental health, substance use, and social need. CHT members are not able to bill for these services.
- Engage with Quality Improvement Facilitator to implement the pilot goals and strategies, conduct continuous quality improvement activities and evaluate pilot processes and outcomes. The practice will meet no less than once a month with their assigned Quality Improvement Facilitator to support implementation activities, including tracking data and conducting regular analysis to identify opportunities for interventions and improved outcomes. The practice agrees to execute a memorandum of understanding (MOU) or a business associate agreement (BAA) with the quality improvement facilitator for sharing protected health information as part of the evaluation process.

Staff types: The Administrative entity program manager will engage with all PCMH practices

to utilize additional funding with the following ratio of Medicaid patients to hire a licensed or unlicensed Mental Health Counselor, Social Worker, Community Health Worker, Certified drug and alcohol counselor, Licensed drug and alcohol counselor, Psychologist or Family Specialist as a member of the primary care team embedded in the practice to ensure the following staffing levels.

Attributed Medicaid Members	Recommended FTE
0-49	Existing CHT Resource
50-249	Centralized CHT Resource
250-849	0.5 Embedded staff
850-2,499	1.0 Embedded staff
2,500+	1.5 Embedded staff

Attributions of Medicaid Patients to Practices will be maintained at the levels from Quarter 1 of 2023 for the first year of the pilot. At the beginning of the second year, Medicaid attributions will be recalculated, and staffing cutoffs adjusted if necessary.

- Utilize screening for mental health, substance use, and social determinant of health needs for individuals and families.

Social Determinants of Health (SDOH) screening

- NCQA requires a comprehensive patient assessment be completed for all patients which includes an examination of the patient's social and mental health influences in addition to a physical health assessment which all PCMHs currently attest to meeting. The Blueprint recommends the use of screening tools for the following SDOH domains: food security and housing instability, according to evidence-based guidelines that are documented in the electronic health record narrative. Specifically, the recommendations for defined age groups are as follows:

Birth to age 11

Social Determinants of Health factors of the family system are reviewed via screening tool or other means and are recorded in the electronic health record narrative.

Standardized tool for periodic **developmental screening** for newborns through 30 months

Bright Futures Periodicity Scale is followed and documented including a maternal depression screen **Edinburgh Postnatal Depression Scale** (EPDS) is administered at 1, 2, 4, and 6 months and as indicated for mothers and/or caregivers and their partners

Ages 12-17

Social Determinants of Health factors are reviewed via screening tool or other means and are recorded in the electronic health record narrative.

Substance Use Screener CRAFFT (Car, Relax, Alone, Forget, Family/Friends/Trouble) is

administered according to evidence-based guidelines. If you choose to use other evidence-based tools in the first year of pilot implementation, the tool(s) must be indicated here:

Tobacco Screening is administered per evidence-based guidelines.

Mental Health Screening using the Patient Health Questionnaire Modified for Adolescents (PHQ-9A) is conducted per evidence-based guidelines.

<u>Ages 18 and up</u>

Social Determinants of Health factors are reviewed via screening tool or other means and are recorded in the electronic health record narrative.

Substance Use Screeners Alcohol Use Disorder Test (AUDIT) and Drug Abuse Screening Test (DAST 10) are administered according to evidence-based guidelines. If you choose to use other tools to screen for alcohol and substance use in year one (1), the tools must be indicated here:

Tobacco Screening is administered per evidence-based guidelines.

Mental Health screening is administered using the PHQ 2(Patient Health Questionnaire) according to evidence-based guidelines

The Blueprint strongly suggests using the PHQ 9 and/or Columbia Suicide Severity Rating Scale (CSSR) screening to address suicide risk.

The practice will utilize Quality Improvement Facilitators to establish care pathways for patients with mental health, substance use disorder and social determinants of health concerns.

Education Participation

The practice will participate in educational opportunities offered by the Blueprint for Health related to mental health and substance use screening and treatment in primary care settings as much as possible.

Evaluation/Measurement Participation – Year One*

The practice agrees to report the following information noted below to the Blueprint Program Manager. The practice agrees to allow access to the quality improvement facilitators and pilot evaluators to collect data in the following areas for evaluation purposes.

- The Blueprint will request these measures be sent by November 15, 2023.
- Practices will then submit to the Blueprint Program Manager, prior to the fifteenth (15th) day of the first month of each calendar quarter ongoing (April, July, and October).

1. Number of FTEs and staffing types hired with expansion funding submitted to the Blueprint Program Manager who will enter via Blueprint Portal.

2. Number of CHT unique patient counts by payer submitted to the Blueprint Program Manager who will enter via Blueprint Portal.
3. Descriptive Episodes of CHT Care (chart review, per practice # TBD) This will be completed by Quality improvement facilitators in October of 2023.
4. Status of practice adoption and implementation via survey sent from Blueprint Central Office and completed by practices.
5. Status of contracting for QI Facilitators, Trainers, and Evaluators will be reported by central office.
6. Trainings offered/number of staff and staff types attending will be collected by Central office.
7. Practice Engagement in Quality Improvement Process will be added to expectations of the quarterly Quality Improvement Facilitators report.

Blueprint for Health Commitment to Practices

Expanded Community Health Team Payments
HSA receive funds based on the number of recommended FTEs payments to administrative entities for hiring of expanded CHT staff as described above. Administrative entities may establish MOUs to receive pass through dollars to allow practices to hire embedded staff as described in the Blueprint manual in collaboration with BP HSA Program Manager.

Blueprint Central Staff and Local Program Manager will support practices with the following:

- Training and learning events to support program implementation
- Medicaid Payments consistent with active caseloads as detailed in payment model
- Practice and community level data and analytic reports
- Technical Assistance in supporting staff in each participating practice
- Quality Improvement Facilitation and support

Practice:

Name of Signer (printed):

Title of Signer:

Signature:

Date:

Blueprint for Health, Health Service Area Program Manager:

Blueprint for Health Program Manager:

Name of Signer (printed):

Signature:

Date:

Scan and email to Blueprint Central office Averiel.Hossley@vermont.gov

Evidence–Based Guidelines and Screening Resources:

1. American Academy of Pediatrics 2023 Periodicity Schedule (Preventive Care/Periodicity Schedule (aap.org))
2. Promoting Food Security for All Children | Pediatrics | American Academy of Pediatrics (aap.org))
3. Pooler J, Levin M, Hoffman V, Karva F, Lewin-Zwerdling A. Implementing food security screening and referral for older patients in primary care: a resource guide and toolkit. AARP website. http://www.aarp.org/content/dam/aarp/aarp_foundation/2016-pdfs/FoodSecurityScreening.pdf. Published November 2016.. Published November 2016.
4. Incorporating Recognition and Management of Perinatal Depression Into Pediatric Practice | Pediatrics | American Academy of Pediatrics (aap.org)Incorporating Recognition and Management of Perinatal Depression Into Pediatric Practice | Pediatrics | American Academy of Pediatrics (aap.org)
5. Protecting Children and Adolescents From Tobacco and Nicotine | Pediatrics | American Academy of Pediatrics (aap.org)
6.Screening for Suicide Risk in Clinical Practice (aap.org)
7. Screening and Behavioral Counseling Interventions to Reduce Unhealthy Alcohol Use in Adolescents and Adults: Recommendation Statement | AAFP
8. Draft Recommendation: Depression and Suicide Risk in Adults: Screening | United States Preventive Services Taskforce (uspreventiveservicestaskforce.org)

Screening Tools:

1. CRAFFT
2. Edinburgh Postnatal Depression Scale (EDPS)
3. PHQ-9 modified for Adolescents (PHQ-A)
4. PHQ-2 and PHQ-9
5. Alcohol Use Disorders Identification Test (AUDIT)
6. Columbia Suicide Severity Rating Scale (CSSR)

Other Resources:

1. Community Health Workers | Vermont Department of Health (healthvermont.gov)