

BLUEPRINT 101: GLOSSARY OF KEY TERMS

Term	Abbreviation	Definition
Accountable Care Organization ¹	ACO	A group of healthcare providers and hospitals who collaborate to provide high-quality, coordinated care to a defined group of patients, with the ability to share in any cost-savings achieved
Administrative Entity	AE	The primary financing and management entity for Blueprint Community Health Teams and Blueprint field staff within each health service area.
Administrative Services Only ²	ASO	A type of self-funded health insurance plan where an employer takes full responsibility for the medical claims made by its employees but contracts an outside organization or third-party administrator to provide specific administrative services, such as claims processing and enrollment. Sometimes these plans are referred to as “self-funded” or “employer-funded” plans.
All-Payer Model ³	APM	An alternative payment model being piloted in the state of Vermont between January 1, 2017 and December 31, 2023 with an optional additional extension year with support from the CMS Innovation Center; a statewide system of ACO participation in which healthcare quality and value are incentivized consistently by the majority of payers (Medicare, Medicaid, and commercial insurers) for the majority of providers with the goal of promoting ongoing health system transformation and improved population health
Blueprint Attributed Patient Population ⁴ (Primary Care)	–	The total number of patients who have received the majority of their primary care services from the providers at a specific practice within the past 24 months; used by Blueprint-participating payers or insurance companies to determine a primary care practice’s core caseload
Care Coordination ⁵	–	Intentional organization of patient care activities and deliberate information sharing among care team members aimed at providing safe, effective, and person-centered health care for patients and their families; often encompassing a wide range of specific activities including assessment of patient needs, support for patient goals, assistance with transitions of care, linkage to

		community resources, ongoing patient follow-up, and high-quality communication
Community Health Team ⁶	CHT	Multidisciplinary teams that collaborate with primary care clinicians to provide evidence-based interventions aimed at promoting whole person health; may include registered nurses, care coordinators, social workers, health educators, registered dietitians, community health workers, and master's level trained behavioral health clinicians; may range from embedded services co-located within a single clinic to centralized services shared across multiple clinics within a region
Community Health Worker ⁷⁻⁹	CHW	A frontline public health worker who has an intimate understanding of the community they serve (usually with shared ethnicity, language skills, or life-experiences) and who functions as a liaison to bridge the gaps between the community and social services, facilitate access to high-quality culturally-competent healthcare, and decrease health disparities; may perform a variety of specific activities including community education, care coordination, health coaching, outreach and advocacy, and social support; associated with improved chronic disease management and mental health outcomes as well as significant cost-savings
Designated Mental Health Agencies ¹⁰	DA DMH	Private, non-profit agencies that partner with the Vermont Department of Mental Health to provide mental health services, program delivery, and outcomes monitoring within a designated region of the state; for example: Health Care & Rehabilitation Services in Windsor and Windham Counties; Howard Center in Chittenden County; and Rutland Mental Health Services in Rutland County
Employee Retirement Income Security Act of 1974 ¹¹	ERISA	A federal law establishing minimum standards for the majority of employer-sponsored retirement and health insurance plans, excluding those that are maintained by government agencies or churches. Qualifying ERISA plans are exempt from many state regulations or requirements.
Federally Qualified Health Center ³⁸	FQHC	Federally funded nonprofit health centers or clinics that serve medically underserved areas and populations. Federally qualified health centers provide primary care services regardless of your ability to pay. Services are provided on a sliding scale fee based on your ability to pay.
Fully-Insured	-	

Plan ^{12,13}		An employer-sponsored health plan in which the employer contracts an insurance company to assume the financial responsibility for its employees' medical claims; in contrast to a "self-funded" or "administrative services only" health plan where the employer assumes direct financial responsibility for all employee medical claims
Healthcare Effectiveness Data and Information Set ¹⁴	HEDIS	A collection of standardized and validated quality measures established by the National Committee for Quality Assurance (NCQA) and widely reported by Medicare, Medicaid, and commercial insurers; consisting of more than 90 measures across the following domains: (1) effectiveness of care, (2) access/availability of care, (3) experience of care, (4) utilization and risk adjusted utilization, (5) health plan descriptive information, and (6) measures reported using electronic clinical data systems; designed to allow for comparisons between health plans and against various regional benchmarks
Health Service Area	HSA	A Blueprint for Health geographic region, based roughly on Vermont Department of Health hospital service areas (version HSA4), which is used for Blueprint program administration and payment purposes.
Hub and Spoke Model ¹⁵⁻¹⁷	–	A novel approach to the provision of evidence-based, medication-assisted treatment for opioid use disorder based on the bidirectional movement of patients between regional opioid treatment program (OTP) specialty addiction centers (Hubs) and community clinics with integrated office-based opioid treatment (OBOT) programs supported by nursing and licensed mental health staff (Spokes); first developed in Vermont in 2013 and subsequently adopted/adapted by multiple states nationwide; associated with significant increases in timely access to treatment for opioid use disorder in the State of Vermont. Wraparound support services are currently Medicaid-funded only, but available to all
Medication for Opioid Use Disorder ¹⁸	MOUD	The current gold standard for the treatment of opioid use disorder; generally consisting of buprenorphine, methadone, or naltrexone administered in combination with harm reduction strategies; highly effective and associated with increased patient survival, improvements in treatment retention, increased employment, and decreased criminal activity. Also known as Medication-Assisted Treatment (MAT) for opioid use disorder.

National Committee for Quality Assurance ¹⁹	NCQA	An independent non-profit organization founded in 1990 with the goal of improving healthcare quality; known for developing the Healthcare Effectiveness Data and Information Set (HEDIS) as well as for the establishment of rigorous programs for health plan accreditation and patient-centered medical home recognition; contracted by a number of federal, state, and private agencies to assist with healthcare innovation, evaluation, and improvement. NCQA sets standards and recognition criteria for Patient-Centered Medical Homes (PCMHs).
Panel Management ²⁰	–	An approach to healthcare delivery in which a care team monitors the health needs of an assigned list of patients and proactively engages them in activities to optimize wellness (rather than relying on them to present for clinical visits and request appropriate care)
Patient-Centered Medical Home ^{21,22}	PCMH	A model of primary care delivery that seeks to provide accessible, comprehensive, whole-person-centered care in a coordinated and team-based fashion; typically allows for the provision of preventive care, acute and chronic disease management, and mental health care within a single setting; certified in accordance with standards published by the National Committee for Quality Assurance (NCQA); and associated with improved clinical outcomes, increased patient engagement in follow-up and treatment, and decreased utilization of the emergency department in many studies
Patient Panel ²⁰	–	A list of patients assigned a provider or care team who is then responsible for delivering preventative healthcare as well as acute and chronic disease management
Peer Support Workers ^{23,24}	PSW	Individuals with lived experience who are trained to support others in recovery from mental health or substance use disorders; generally characterized by a more informal and less hierarchical dynamic than that of the traditional health care team; associated with improved outcomes including increased hopefulness and decreased healthcare utilization among patients in recovery https://mentalhealth.vermont.gov/services/peer-services/vermont-peer-services-organizations
Per Member Per	PMPM	

Month ⁴ (Blueprint)		A capitated payment model in which practices receive a standardized monthly payment from an insurer to cover a defined monthly set of services provided to their patients (in contrast to a fee-for-service model, in which insurance payment is variable depending on the specific services provided); for population-based payments, this is calculated by multiplying the attributed patient population of a provider for a specific insurer by a predetermined rate. Also known as a Per Patient Per Month (PPPM) rate.
Population Health ²⁵	–	The health status and outcomes of a group of individuals, often identified according to geography, age, sex, ethnicity, occupation, or other specific factors
Pregnancy Risk Assessment Monitoring System ²⁶	PRAMS	Vermont PRAMS is an ongoing survey of Vermont mothers who have recently given birth. PRAMS is a project of the Centers for Disease Control and Prevention (CDC) and the Vermont Department of Health. The goal of PRAMS is to improve the health of mothers and infants by reducing adverse outcomes such as low birth weight, infant mortality and morbidity, and maternal morbidity.
Quality Improvement Model ^{27,28}	QI	A systematic approach emphasizing continuous efforts to reduce variation and improve the quality of healthcare delivery uses a variety of approaches and tools, including the Model for Improvement (MFI), workflow mapping, assessments, audit and feedback, benchmarking, and best practices research. The most common approach, Plan Do Study Act (PDSA) cycle involves: <ul style="list-style-type: none"> ● <u>P</u> = Plan → understand the local environment; develop a team, set project aims, and identify key interventions to meet these aims ● <u>D</u> = Do → implement the proposed intervention on a small scale; collect data to measure improvement ● <u>S</u> = Study → analyze and display data; identify key lessons learned ● <u>A</u> = Act → use lessons learned to determine best next steps, including further adjustment of an intervention or adoption on a larger scale
Resource Use Index Score ²⁹	RUI	This measure is based on software developed by HealthPartners as part of their Total Cost of Care (TCOC) measurement system, which has been endorsed by the National Quality Forum (NQF). This methodology applies nationally accepted weighting methods such as Medicare Severity Diagnosis Related Groups (MS-DRGs)

for inpatient services, Current Procedural Terminology codes (CPTs) and associated Ambulatory Payment Classifications (APCs) for outpatient facility services, and CPTs and associated Resource-Based Relative Value Scale (RBRVS) relative weights for professional services) to measure the relative intensity of services. Each patient-centered medical home (PCMH) in the Blueprint program receives an RUI score relative to the state average, which is indexed at 1. The lower the RUI score the better a practice ranks for their attributed adult members and pediatric members."

Self-Management Education ^{30,31}	SME	Evidence-based educational programming (such as the National Diabetes Prevention Program) aimed at helping individuals with chronic conditions better manage their own health and improve wellness; with local programming supported by the Vermont Blueprint for Health, managed by the Vermont Department of Health, and found at the following website: https://www.myhealthvyt.org/
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Social Determinants of Health ^{32,33}	SDOH	The larger social conditions that affect a person’s health including, but not limited to: housing, transportation, education, economic opportunity, employment, income, air and water quality, access to healthy food, access to green space, violence, and racism/discrimination; often identified as key contributors to disparities between populations
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Support and Services at Home ³⁴	SASH	A voluntary statewide program providing services to support health and wellness among Vermont Medicare beneficiaries who live independently at home and in senior housing; staffed by local program coordinators and nurses who collaborate with participants on the creation of individualized healthy living plans, host optional wellness check-ins, and partner with community organizations to develop social, educational, and exercise programming; associated with increased engagement in primary care, decreased Emergency Department utilization, and improvements in blood pressure and diabetes management among program participants
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Third-Party Administrator ³⁵	TPA	A company contracted by a health insurance provider to perform administrative duties such as claims processing, billing, and enrollment
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Vermont Chronic Care Initiative ³⁶	VCCI	A program that provides short-term case management services to Vermont Medicaid enrollees with complex health and resource
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needs; ultimately intended to link participants to local patient-centered medical homes, care coordination services, self-management programming, and resource supports

Women's Health Initiative³⁷

WHI

A Blueprint program providing dedicated training, funding, and staff to participating PCMH and OB/GYN practices supporting enhanced psychosocial screening, comprehensive family planning counseling, and timely access to long-acting reversible contraception (LARC) among individuals ages 15–44 years of age who can become pregnant; planned to be renamed in 2023 to be more inclusive of transgender, nonbinary, and genderfluid identities. Currently only Medicaid funded, but available to all patients.

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