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Blueprint for Health 101

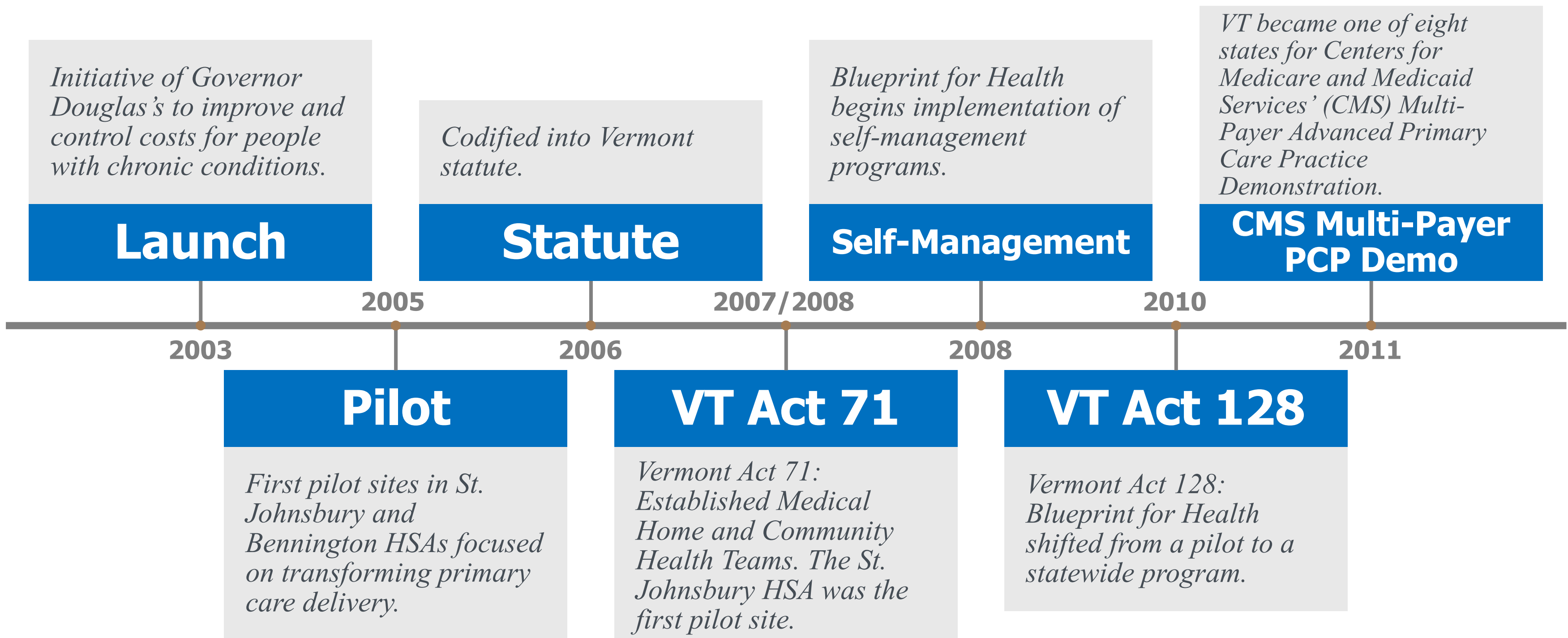
July 2020

Vermont Statutory Framework
Act 128 Mission of Blueprint For Health

"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."

History of Blueprint for Health

2003-2011



History of Blueprint for Health

2011-2017

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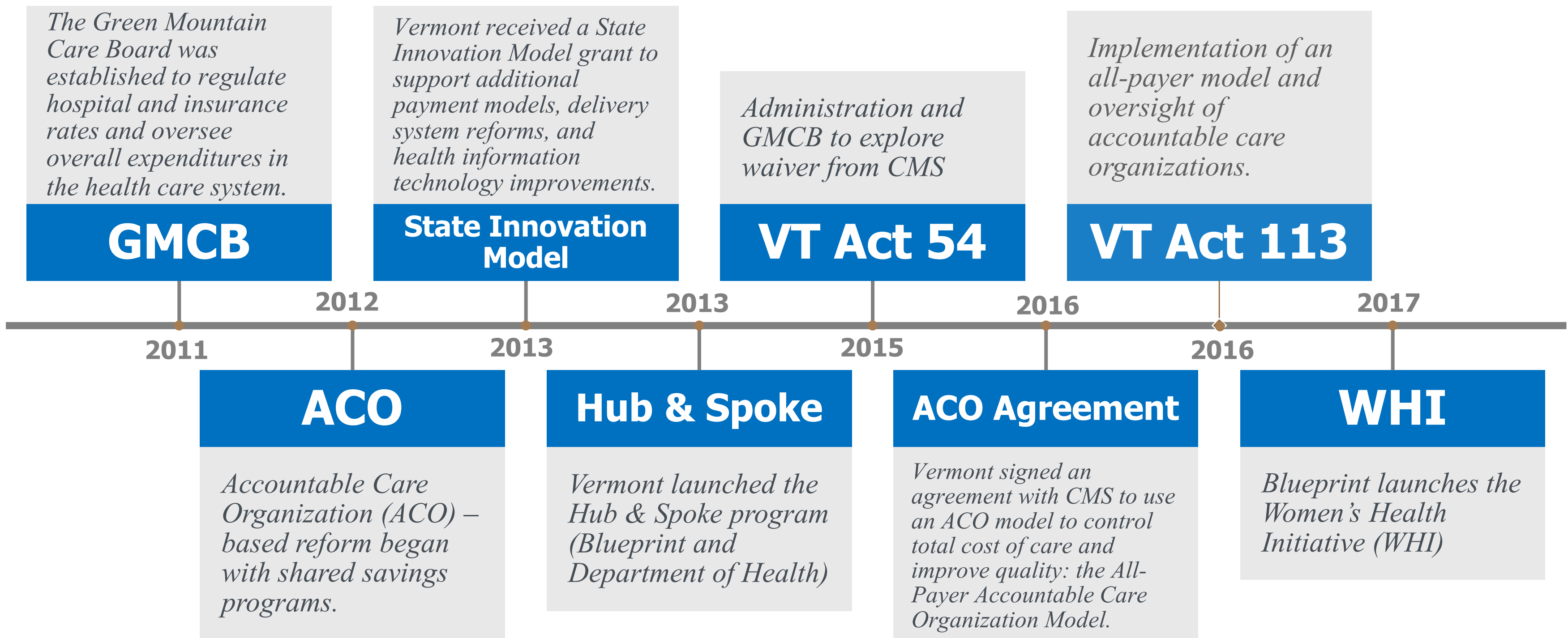
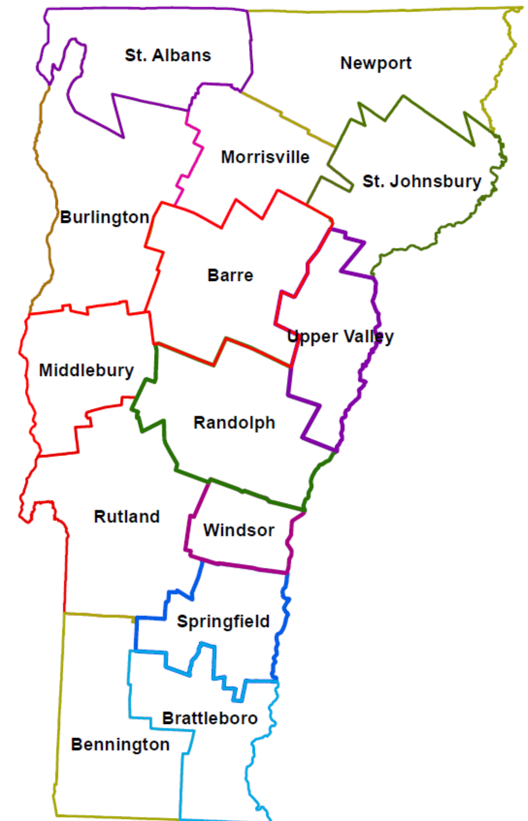


Statewide Network

- Program Managers
- Quality Improvement Facilitators
- Community Health Team Leaders
- Medication Assisted Treatment
- Women's Health Initiative

Contact information:
https://blueprintforhealth.vermont.gov/contact-us



Improved System of Care

Patient Experience: a medical visit in which patients are **seamlessly: asked** about their reproductive, physical, and emotional health and wellness, **skillfully and empathically** engaged, and **connected to resources** and **able to access reproductive health services without barriers**

Community Experience: a broad **agreement** about the interrelationship between physical health, mental health, substance use, and social need and a **coordinated effort to recognize and alleviate suffering and improve care** beginning in the medical visit

Programs

- **Patient-Centered Medical Homes** improve the quality and cost-effectiveness of primary care
- **Community Health Teams** bridge health and social services
- **Hub and Spoke** provides opioid use disorder treatment
- **Women's Health Initiative** increases pregnancy intention, healthy families

Patient Centered Medical Home NCQA

This Photo by Unknown Author is licensed under CC BY-NC

Blueprint 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) to become and to maintain their status as Blueprint Advance Primary Care Practices. A copy of the standards can be found on the NCQA website at http://www.ncqa.org..
- **Continuous Quality Improvement:** Ongoing transformation work as a medical home

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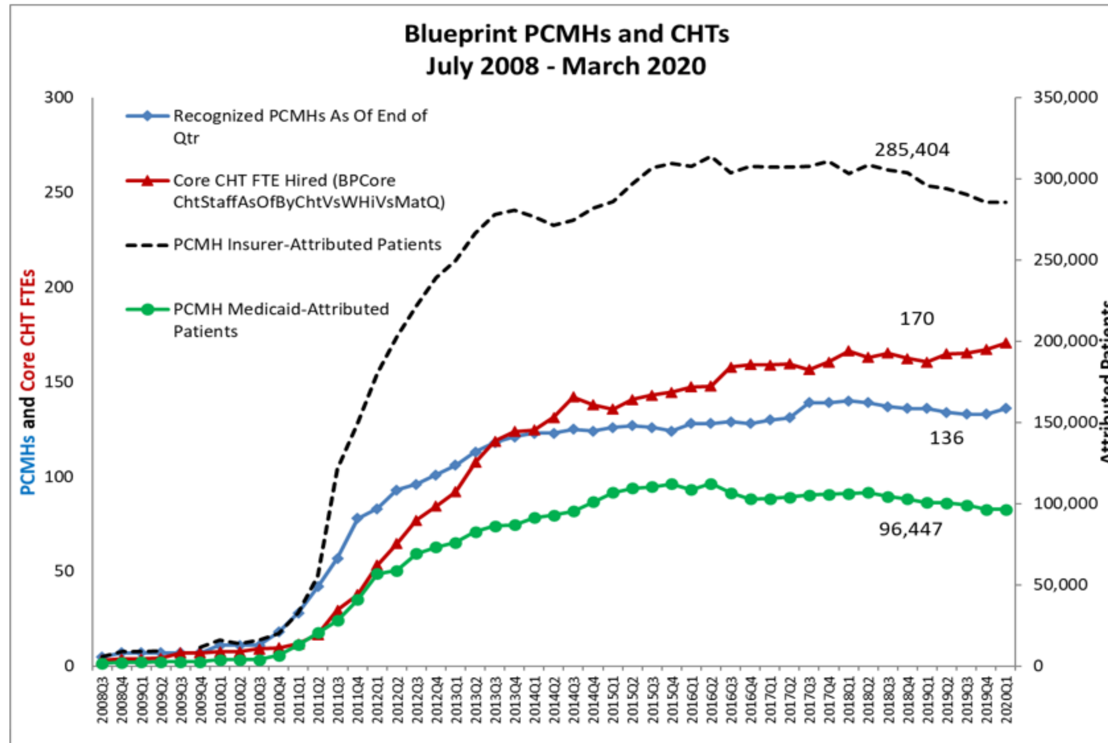
PCMHC



Strong Primary Care through Patient Centered Medical Homes

© 2013 The MacColl Center for Health Care Innovation and Qualis Health.

Suggested citation: Safety Net Medical Home Initiative. Change Concepts for Practice Transformation. 4th ed. Seattle, WA: Qualis Health and the MacColl Center for Health Care Innovation; May 2013.

Quality Improvement Facilitator

- The Quality Improvement Facilitator helps engaging practices/organizations work through the continuous quality improvement process to:
  - Achieve, maintain, and continue improvement on practice transformation as a Patient Centered Medical Home
  - Meet standards and continue improvement on population health quality and payment reform efforts, defined by the Blueprint, Green Mountain Care Board, or Accountable Care Organizations (ACOs)
  - Achieve and continue improvement on clinical, cost, or patient experience priorities identified by the practice
  - Assist practices/organizations prepare for and maintain National Committee for Quality Assurance (NCQA) Patient-Centered Medical Home (PCMH) and Patient-Centered Specialty Practice (PCSP) Recognition:

HSA Program Manger

- The Program Manager is hired by the Administrative Entity and is responsible for the implementation of the Grant Agreement.
- The Program Manager has primary oversight and responsibility for data collection, data entry, and completion of reports as required by the State for the continuation of multi-insurer funded payments to the Administrative Entity to support CHT and to PCMHs within the Health Service Area. Commercial and public payers require detailed information on providers, practices, and CHT staff in order to implement enhanced payments.
- Monthly invoices per contract sent to:

  AHS.DVHAInvoices@vermont.gov

Hub & Spoke – Medication Assisted Treatment

Hub & Spoke Program started in 2013

Hubs: Enhanced OTPs (9 program sites)

Dispense Buprenorphine & Vivitrol (buy & bill) in addition to Methadone
Augment staffing for health home services (care managers, counselors, nurses, and psychiatry)
Monthly bundled rate

Spokes Enhance OBOTs (113 practice sites)

1 FTE RN & 1 FTE Licensed Addictions/Mental Health Counselor for 100 Medicaid Members provide health home services
Hired and deployed as part of Blueprint Community Health Team

Consultation between Hubs and Spokes

Medicaid engagement

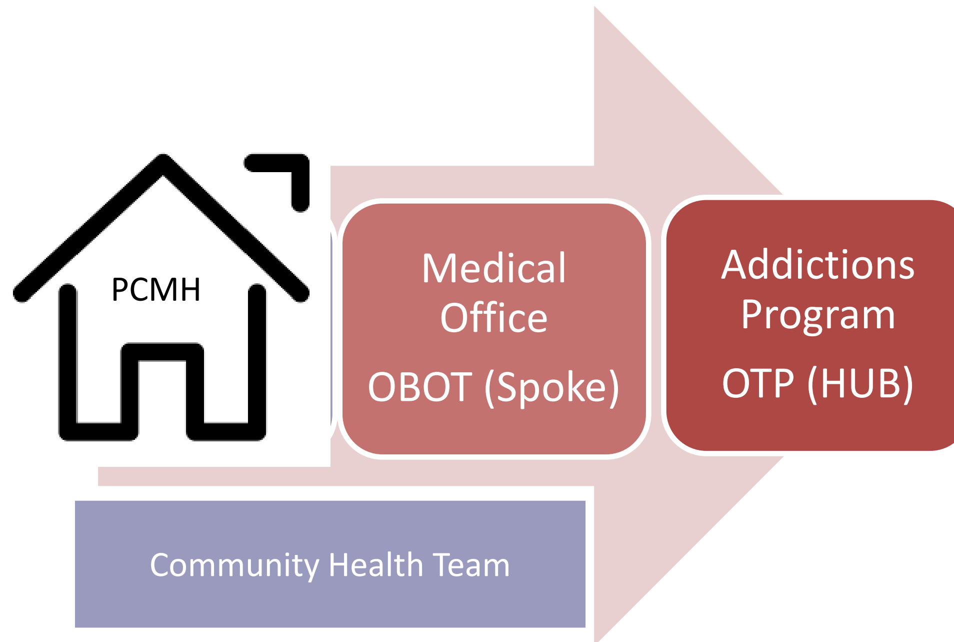
Agency endorsed caseload expansion
Medicaid State Plan Amendment "Health Home" chronic condition of opioid addiction (initially revenue neutral expansion of services)

Vermont's Response to Opioid Use Disorder

- Model has two levels of care
  - High intensity (daily) methadone or buprenorphine along with therapy and other services
  - Ongoing follow-up (weekly, monthly, or less frequently) care for medications, therapy, other services
- The Affordable Care Act (passed 2010) included a special Medicaid waiver that Vermont obtained to help subsidize the hub and spoke model.

Hub & Spoke Health Home for Opioid Addiction

Section 2307 Affordable Care Act



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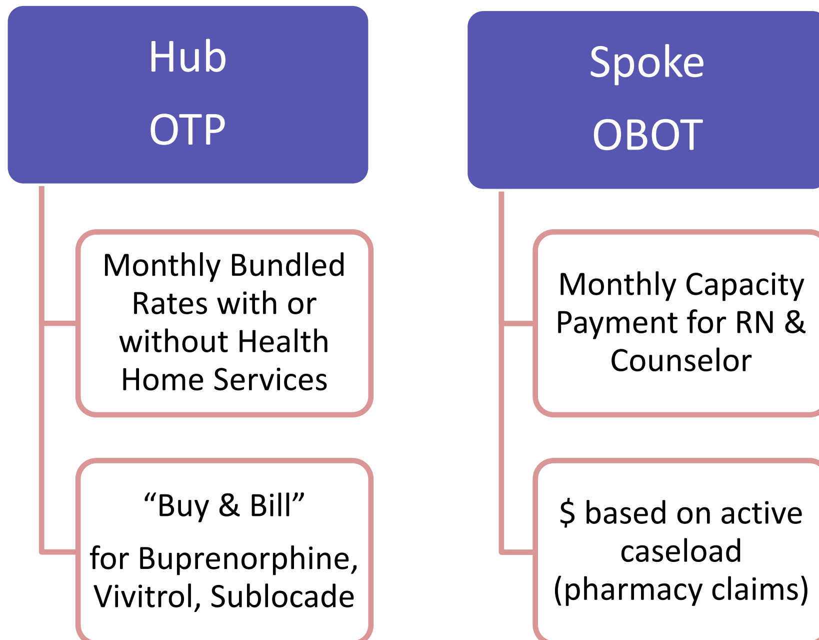
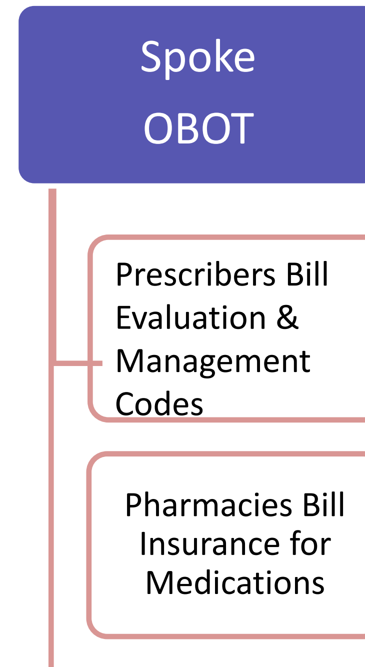
Payment Changes



Not Changed



MAT Induction in the Emergency Department (ED)

- Triage workflow for hospital ED that promotes buprenorphine inductions and treatment referrals for admitted patients experiencing opioid withdrawal
- ED providers write a 72-hour buprenorphine prescription to support a warm handoff into a Hub or Spoke
- Some hospitals utilize Recovery Coaches for patient support and information gathering

HSAs with ED Inductions

Active sites:

- Burlington
- Barre
- Middlebury
- Windsor
- Randolph
- Brattleboro
- Bennington

Sites estimated to launch by Sept 2020:

- St. Albans
- Morrisville
- St. Johnsbury

MAT/Spoke Funding

- Spoke payments are based on the average quarterly number of unique patients in each Health Service Area (HSA) for whom Medicaid paid a Buprenorphine or Vivitrol pharmacy claim during the most recent three-month period.
- This is designed to reflect the active caseload for each provider and for the region. The total number of unique patients served is rounded to next increment of 25 to arrive at a total count in the region for staffing purposes. For example, a count of 167 patients in active treatment is rounded to 175 for the staffing model. This allows staff to be hired and deployed increments of .25% Full Time Equivalent (FTE).
- The patient counts for each Health Service Area (HSA) are calculated monthly.
- Medicaid makes the payments to the lead administrative agent in each Blueprint Health Service Area as part of the Medicaid Blueprint Community Health Team payment every quarter.
- The Blueprint Program Director in each HSA is responsible for organizing both the Community Health Team staff and the Spoke Staffing on behalf of the practices and programs in the region.

Spoke Hiring

- The Administrative Entity may, at the discretion of the Blueprint Program Manager, create an agreement to "pass-through" funds to a participating provider organization that becomes the hiring entity for Spoke, CHT or WHI staff.
- As part of the Blueprint for Health Community Health Teams (CHTs), a Registered Nurse and a Licensed Counselor are required. The Administrative Entity requires permission from the Blueprint Executive Director to hire licensure track clinicians.

Please see our Spoke guide for more information on staffing: https://blueprintforhealth.vermont.gov/implementation-materials

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Spoke Patients, Providers & Staffing: May 2020

Region	Total # Providers prescribing patients	# Providers prescribing to ≥ 10 pts	Staff FTE Hired	Medicaid Beneficiaries
Bennington	20	6	8.35	411
St. Albans	22	9	11.25	516
Rutland	18	8	9.8	411
Chittenden	106	20	16.45	765
Brattleboro	7	4	3.19	131
Springfield	9	6	3.7	179
Windsor	14	6	1.5	241
Randolph	7	2	2.21	84
Barre	22	5	6.9	237
Lamoille	24	9	4.9	233
Newport & St. Johnsbury	22	7	2.8	222
Addison	12	5	3.5	146
Total	**263***	**77***	**74.55**	**3565**

Table Notes: Beneficiary count based on pharmacy claims for Buprenorphine and Vivitrol, March 2020 – May 2020; an additional **270** Medicaid beneficiaries are served by **61** out-of-state providers. Staff hired based on Blueprint portal report, as of 6/1/2020. *15 providers prescribe in more than one region.

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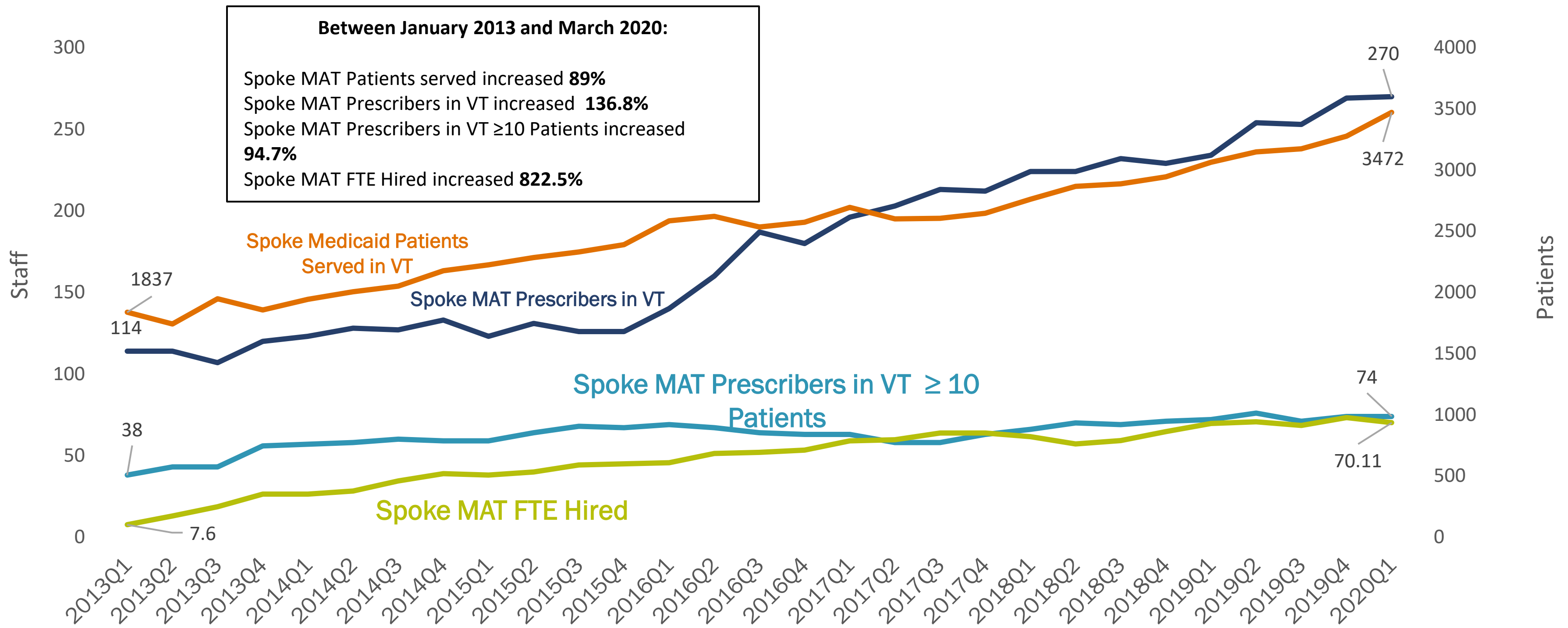

Women's Health Initiative
Healthier Women, Children, and Families

- In Vermont…
  - 50% of all pregnancies are unintended
  - The unintended pregnancy rate has been the same for ~20 years
  - Healthy Vermonters 2020 goal is to reduce the rate of unintended pregnancy to 35%

Interventions That Help Lower Risks for Unintended Pregnancy

- Access to comprehensive family planning counseling
  - Increased access to preconception counseling has been shown to improve maternal and infant outcomes
  - Increased access to contraceptive counseling has been shown to be an effective intervention for reducing the rate of unintended pregnancies
- Psychosocial screening, intervention, and navigation to services
  - Integrated care interventions, such as screening, brief intervention and referral to treatment (SBIRT), have shown improved outcomes across populations, especially, substance use and mental health disorders

Women's Health Initiative Presentation (January 2017), The Best Intentions: Unintended Pregnancy and the Well-Being of Children and Families., NEJM, 1995; 333: 1363-1365 and IOM Division of Health Promotion and Disease Prevention, National Academy Press, 1995, Colorado Department of Public Health and Environment, Taking the Unintended Out of Pregnancy: Colorado's Success with Long-Acting Reversible Contraception, January 2017, and CDC MMWR Providing Quality Family Planning Services, 2014; 64: 1-29.

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Design

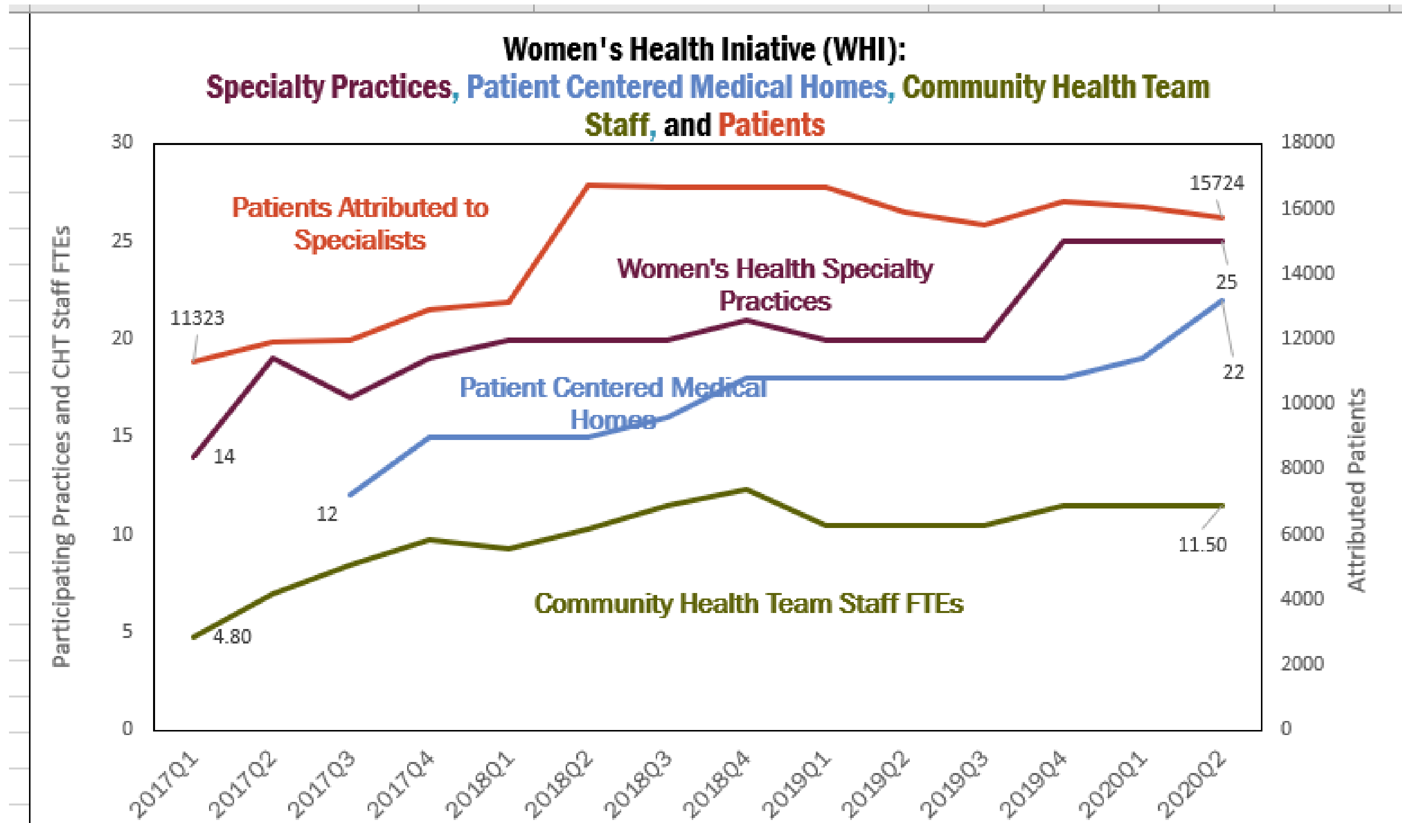
Payment Model

- 3 forms of payment based on attribution of women ages 15 to 44:
  - Recurring per member per month (PMPM) payments to WHI practices
  - Recurring payments to support WHI Community Health Team (CHT) staff to the CHT administrative entities (OB/GYN only)
  - A one-time per member payment (PMP) to support stocking of Long Acting Reversible Contraceptive (LARC) devices to WHI practices.
- Paid by Medicaid only

WHI Community Health Team

- Embeds a licensed mental health provider into OB/GYN practices
- Funds a floor of at least 0.5 full-time equivalent community health team member per (OB/GYN) practice
- Supplemental CHT payments, and by extension the number of full time equivalent (FTE) supplemental CHT staff members, are intended to be equal to approximately 1 FTE per every 1,200 patients.

WHI DATA



Self-Management Background

- Since 2008, the Blueprint for Health has offered workshops that help people learn skills to better manage chronic conditions. The current way of administering these programs and some of the offerings themselves is no longer achieving the same results as when the programs were introduced in 2008.

- Topics have included healthy living with diabetes, diabetes prevention, tobacco cessation, mental health and emotional well-being, and living with chronic pain. Many participants have gained a better understanding of their health condition, explored their motivations, identified their strengths, and developed plans for achieving their health goals, all with the help and support of coaches and peers.

Self-Management Programs

- As Vermont health reforms continue to progress, the Blueprint for Health looks for opportunities to further align with OneCare Vermont in support of the All Payer Model. The Blueprint Executive Committee has previously provided positive feedback about a plan to transition the Self-Management Programs to OneCare Vermont in 2020.

Self-Management
Next steps

The Blueprint's priorities for this transition include:

- Availability of all self-management offerings to the whole population, regardless of attribution or ability to pay
- Systematic identification of and outreach to Vermonters who could benefit from programming addressing early intervention and/or effective management of pre-diabetes, diabetes, pre-hypertension, and hypertension
- New offerings that are more accessible and successful than the current suite of self-management workshops. These will likely need to include remote and asynchronous options.
- Continued offering of CDC's Diabetes Prevention Program and Diabetes Self-Management Program for at least one year – this requirement may be met through online offerings utilizing the Vermont Health Learn platform
- Program evaluation including ongoing feedback from users and continuous quality improvement

Transition of program to OneCare

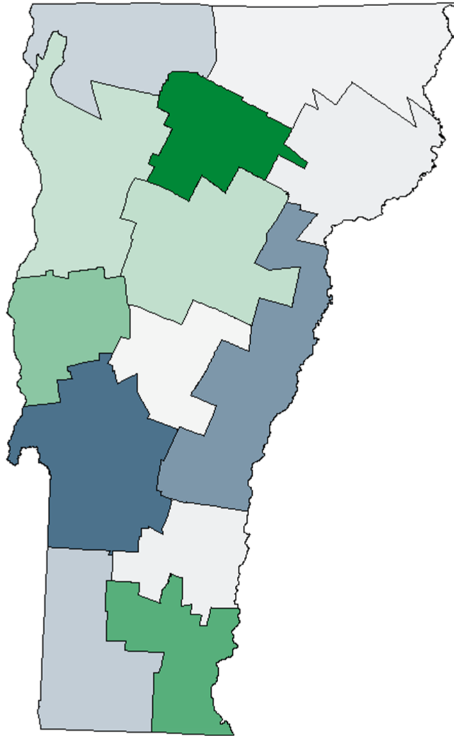
The transition of the self-management programs to OneCare Vermont offers some significant advantages for this programming and the people it serves. These advantages include:

- Advanced analytics tools that can be used to identify people who may benefit from the programs based on diagnoses and other risk factors and to assess the impact of engagement
- A close provider network with well-established and well-attended provider education offerings that can be utilized to build awareness and promote referrals
- A social marketing function that can help directly connect Vermonters with programs
- The opportunity to develop a seamless continuum of offerings from primary prevention through chronic disease self-management
- More latitude to offer incentives, should they be determined to be effective in promoting meaningful engagement with the programs and return on investment

2019 Workshops

Workshop Type	Planned	Completed	Number of Participants
Chronic Disease	26	17	153
Chronic Pain	15	12	91
Diabetes	27	23	203
DPP	38	8	314
WRAP	9	0	74
Tobacco	139	33	371

Health and Payment Reform in Vermont



Vermont's All-Payer Accountable Care Organization Model: Brief Overview

October 7, 2019 - Waterbury, VT

Pat Jones, Deputy Director of Payment Reform
Department of Vermont Health Access

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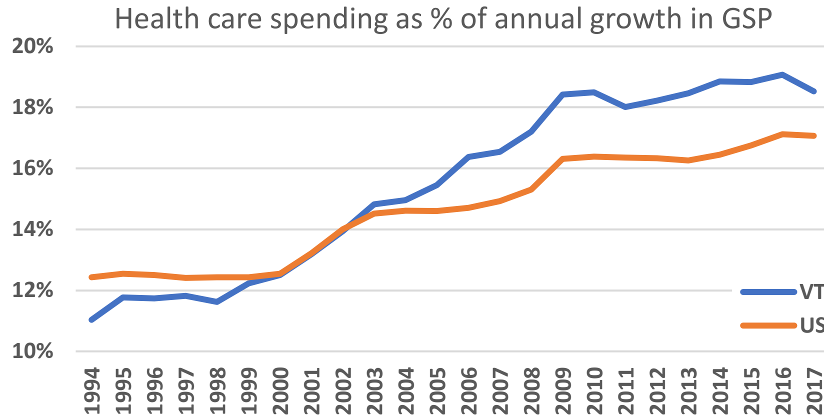
Problem: Cost Growth is Unsustainable, and Health Outcomes Must Improve

Cost Growth

- In 2017, the most recent year of data available, health care spending in Vermont grew 1.7%.
- Vermont's health care share of state gross product devoted to health care spending was 18.5% in 2017, vs. 11.8% in 1995.



Source: 2017 Vermont Health Care Expenditure Analysis, available at https://gmcboard.vermont.gov/data-and-analytics/analytics-rpts.

Health Outcomes

- Chronic diseases are the most common cause of death in Vermont. In 2014, **78% of Vermont deaths** were caused by chronic diseases.
- Medical costs related to chronic disease were over **$2 billion in 2015** and are expected to rise to nearly $3 billion by 2020.
- Vermont's **death rates from suicide and drug overdose** are higher than the national average.

Sources: Vermont Dept. of Health, Kaiser Family Foundation

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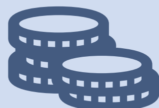
Vermont's Solution: The Vermont All-Payer Accountable Care Organization (ACO) Model Moves Away From Fee-for-Service Reimbursement for Accountable Care Organizations



Test Payment Changes

Population-Based Payments Tied to Quality and Outcomes

Increase Investment in Primary Care and Prevention

Transform Care Delivery

Invest in Care Coordination

Incorporate Social Determinants of Health

Improve Quality

Improve Outcomes

Improve access to primary care

Reduce deaths from suicide and drug overdose

Reduce prevalence and morbidity of chronic disease

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All-Payer Model: What Is It?

- The All-Payer Model is based on an agreement between the State and the Centers for Medicare and Medicaid Services (CMS) that allows Vermont to explore new ways of financing and delivering health care, <u>with Medicare's participation</u>.

- The All-Payer Model enables the three main payers of health care in Vermont – Medicaid, Medicare, and commercial insurance – to pay for health care differently than through fee-for-service reimbursement.

- The All-Payer Model provides Vermont the opportunity to improve health care delivery to Vermonters, changing the emphasis from seeing patients for episodic illness to providing longitudinal and preventive care.

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VT All-Payer ACO Model Agreement Between CMS and State of Vermont

Agreement signed in October 2016 was the first of 3 steps in creating an All-Payer Model:

- **Step 1:** Agreement between CMS and VT provides an opportunity for private-sector, provider-led reform in VT
- **Step 2:** ACO and payers (Medicaid, Medicare, Commercial) work together to develop ACO-level agreements
- **Step 3:** ACO and providers that want to participate work together to develop provider-level agreements

Term of Agreement: 2017 was implementation year; 5 performance years (2018-2022)

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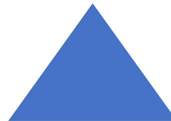
Vermont's Responsibilities under the All-Payer ACO Model Agreement

Cost Growth and Population Health/Quality	Alignment and Scale
• Limit spending growth on certain services ➢ Separate targets for Medicare and "all-payer" beneficiaries (most Vermonters) • Meet targets for 20 quality measures, including three population health goals ➢ Improving access to primary care ➢ Reducing deaths due to suicide and drug overdose ➢ Reducing the prevalence and morbidity of chronic disease	• Ensure payer-ACO programs align in key areas, including ➢ Attribution methodologies ➢ Services ➢ Quality measures ➢ Payment mechanisms ➢ Risk arrangements • Steadily increase scale (the number of people in the model) over the five years of the Agreement



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Blueprint Executive Committee

The Blueprint Executive Committee provides high-level multi-stakeholder guidance on complex issues. The Blueprint Executive Committee advises the Blueprint Director on strategic planning and implementation of a statewide system of well-coordinated health services with an emphasis on prevention. The Blueprint Executive Committee Members represent a broad range of stakeholders including professionals who provide health services, insurers, professional organizations, community and nonprofit groups, consumers, businesses, and state and local government.

Stakeholders

- **All AHS Departments – VDH, DMH, DAIL, etc.**
- **Bi-State Primary Care Association**
  - Nonpartisan, nonprofit organization that represents New Hampshire and Vermont's 28 Community Health Centers serving over 315,400 patients at 143 locations across every county in New Hampshire and Vermont. Bi-State works to promote access to quality, affordable primary health care with an emphasis on reaching underserved populations.
- **VCHIP Vermont Child Health Improvement**
  - a population-based maternal and child health services research and quality improvement program of the University of Vermont.
- **VPQHC Vermont Program for Quality in Healthcare**
  - is a 501(c) (3) nonprofit organization designated by the Vermont Legislature in 1988 as an independent, non-regulatory, peer review committee. Our organization brings together the entire spectrum of health care voices to focus on quality analysis and improvement.

Stakeholders

- **Vermont Association of Hospitals and Health Systems (VAHHS)**
  - is a member-owned organization comprised of Vermont's network of not-for-profit hospitals. We are committed to building a vibrant, healthy Vermont. Our work includes advocacy, policy development, education and research

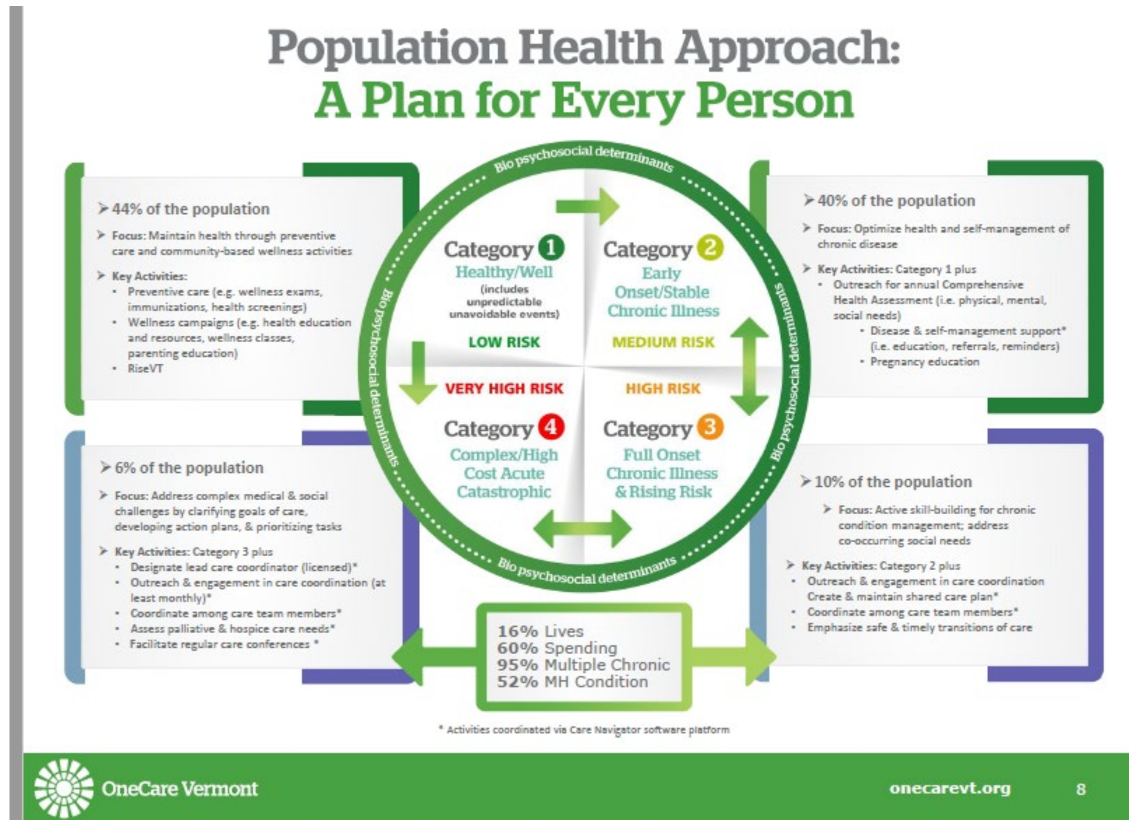
- **Vermont Chronic Care Initiative (VCCI) DVHA**
  - Works with health care providers to identify Vermonters new to Medicaid and dually eligible members with complex needs who would benefit from care management services.

OneCare

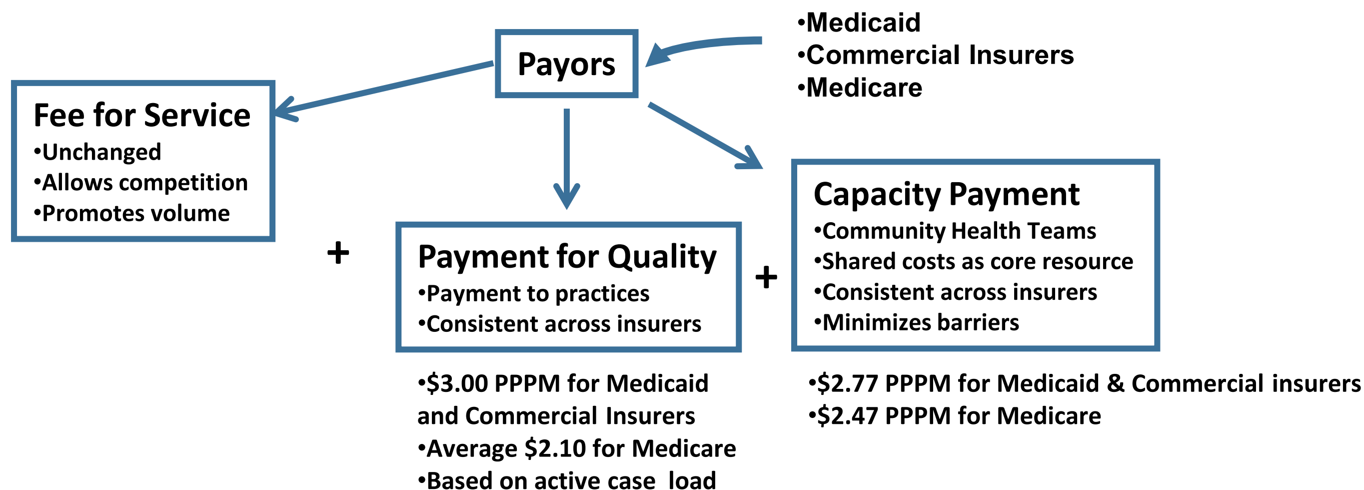
- *"OneCare is a community of health care providers driving system change and improvement by leveraging innovation, information, investment, access, and education. The focus is on improved health, higher quality, lower cost increases and greater coordination of care for all of our Vermonters."*

https://www.onecarevt.org/about-2/

Vermont Population Health Model



Vermont Multi-Payor Payment Reforms for Primary Care



Patient Centered Medical Homes strong primary care foundation **Community Health Teams** bridge health & social services **SASH** for healthy aging-in-place, **Hub & Spoke** for opioid addiction treatment, **Women's Health Initiative** increase pregnancy intention, healthy families

Blueprint Payments

- Information entered into the Blueprint portal generates provider rosters that are sent to insurers, used for calculating primary care patient attribution and Blueprint payments.
- The costs of PCMH payments and CHT staffing for primary care patients are shared across insurers: Medicare, Medicaid, BCBSVT, Cigna, MVP

Health Service Area Grant

- Grant to each administrative entity signed yearly
- Provides funds for the Program Manager salary, a Quality Improvement Facilitator (in some
- Until October 1, 2020, provides funds for a Self-Management Regional Coordinator and Self-Management program costs

PCMH Payments

- As the result of recognition as a PCMH, practices receive payments from insurers for attributed lives in the practice (Per Member Per Month).
- PCMH payments are made directly to the practice by insurers.
- PCMH payments have 3 components:
  - Base payment ($3.00 PMPM commercial; $4.65 PMPM Medicaid; $2.05 PMPM Medicare).
  - Performance payment for patient healthcare utilization at the practice level (up to $0.25 PMPM; paid by commercial and Medicaid).
  - Performance payment for quality measure outcomes at the HSA level (up to $0.25 PMPM; paid by commercial and Medicaid).

CHT Payment Structure

- The investment in CHT capacity provides Vermonters with greater access to multi-disciplinary medical and social services in the primary care setting.
- Health Service Areas receive funds from insurers for staffing a Community Health Team. ($2.77 PMPM commercial and Medicaid, and $2.51 PMPM Medicare, for core/primary care staffing).
  - There are different models for staffing a Community Health Team. An Administrative Entity may decide to hire on their own, pass through money directly to practices for hiring staff, or contract with another entity such as local Designated Agency.
- CHT payments may include funds for core (or primary care) CHT staff, MAT CHT staff, and/or Women's Health Initiative CHT staff.

Reporting Staffing

https://vitl.knack.com/blueprint-portal-at-vitl

CHT/MAT/WHI Staffing, Practice Descriptors, Practice Rosters, and Practice Demographics: Enter updated CHT/MAT/WHI staffing, Practice descriptive information, Practice rosters and Practice demographic information.	October 15, 2020 January 15, 2021 April 15, 2021 July 15, 2021

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NCQA Reporting

Monitoring NCQA PCMH Recognition: Each quarter, the State shall make available to the Program Manager a list of Practices which are scheduled to undergo NCQA PCMH recognition approximately 6 months in the future. For those identified Practices, the Program Manager, in partnership with the assigned Blueprint Practice Facilitator, shall closely monitor progress towards the reporting date and ensure all appropriate Practice and provider information is updated in the Blueprint Portal (or other data reporting system) accordingly.	October 15, 2020 January 15, 2021 April 15, 2021 July 15, 2021 (for each such date, with respect to Practices identified to Subrecipient within the prior quarter)

Reporting Total Unique Patient

Practice TUP: Enter Practice-level patient counts which may later be used to verify CHT staffing ratios.	December 15, 2020 March 15, 2021 June 15, 2021 September 15, 2021

Incomplete data/unable to pay

- Rosters must be complete and updated!
- If we do not have the correct information you will be unable to get payment!

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)

Central Office Staff – June 13, 2020

Name	Title
Beth Tanzman	Executive Director
Julie Parker	Assistant Director
Mara Krause Donohue	Assistant Director
Brianna Nalley	Project Administrator
Mary Kate Mohlman	Health Services Researcher
Tim Tremblay	Data Analytics and Info Administrator
Laura Wreschnig	Data Analytics and Info Administrator
Jennifer Herwood	Payment Operations Administrator

Health Service Area	Central Blueprint Contact
Barre	Julie Parker
Bennington	Julie Parker
Brattleboro	Julie Parker
Burlington	Mara Donohue
Middlebury	Mara Donohue
Morrisville	Julie Parker
Newport	Julie Parker
Randolph	Julie Parker
Rutland	Mara Donohue
St. Albans	Mara Donohue
St. Johnsbury	Mara Donohue
Springfield	Julie Parker
Windsor	Mara Donohue

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Central Blueprint Staff

ols.

Role	Name	BP Subject Area (s)
Assistant Director	Mara Donohue, MPP	1. HSA oversight (as listed) 2. Care Coordination 3. Accountable Communities for Health
Assistant Director	Julie Parker, LCMHC	1. HSA oversight (as listed) 2. Women's Health Initiative
Project Administrator	Brianna Nalley, MPH	1. Spoke Implementation 2. Self-Management 3. All Learning Collaboratives and Trainings
Blueprint Data Analytics/Information Administrator	Timothy Tremblay, MS	1.Data related contract management 2.Back up for Blueprint Payments and data reporting
Payment Operations Administrator	Jenn Herwood, MS	1.Manage PCMH and CHT Payment 2.Blueprint Portal questions and access 3.Payment Implementation Workgroup 4.Patient Experience Survey
Health Service Researcher	Mary Kate Mohlman, PhD MS	1. Develop and manage analytic agenda and products 2. Lead research and evaluation design 3. Support data governance and inter-department/agency analytic projects
Blueprint Data Analytics/Information Administrator	Laura Wreschnig, MA	1. Managing WHI and Spoke payments 2. Research and Analytics around WHI and Spoke Programs

Meetings

- MAT 2x options per month
- WHI 1 for leadership 1 for in practice staff
- All Field Team Quarterly
- PM/CHT/QI opposite months of AFT
- Executive Committee
- Payment Implementation Group monthly

Questions/Thoughts

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Resources

Blueprint for Health Manual
https://blueprintforhealth.vermont.gov/sites/bfh/files/Blueprint-Manual-Oct1-2018.pdf

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

VERMONT Blueprint for Health

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