Program Design

4.13.2023

BLUEPRINT EXPANSION PILOT

VERMONT Blueprint for Health

www.blueprintforhealth.vermont.gov

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Workgroups and Committees

The Blueprint for Health is guided by stakeholder groups that include experts in healthy systems design, evaluation, payment implementation, and mental health and substance use disorder treatment.

Blueprint Executive Committee

Payment Implementation Workgroup

Blueprint News

News

March 23, 2023

BP Executive Committee Minutes March 16 2023 Now Availble

News

March 14, 2023

BP Executive Committee Agenda March 16 2023

News

February 21, 2023

DVHA Is Seeking to Establish Contracts for Quality Improvement Facilitators

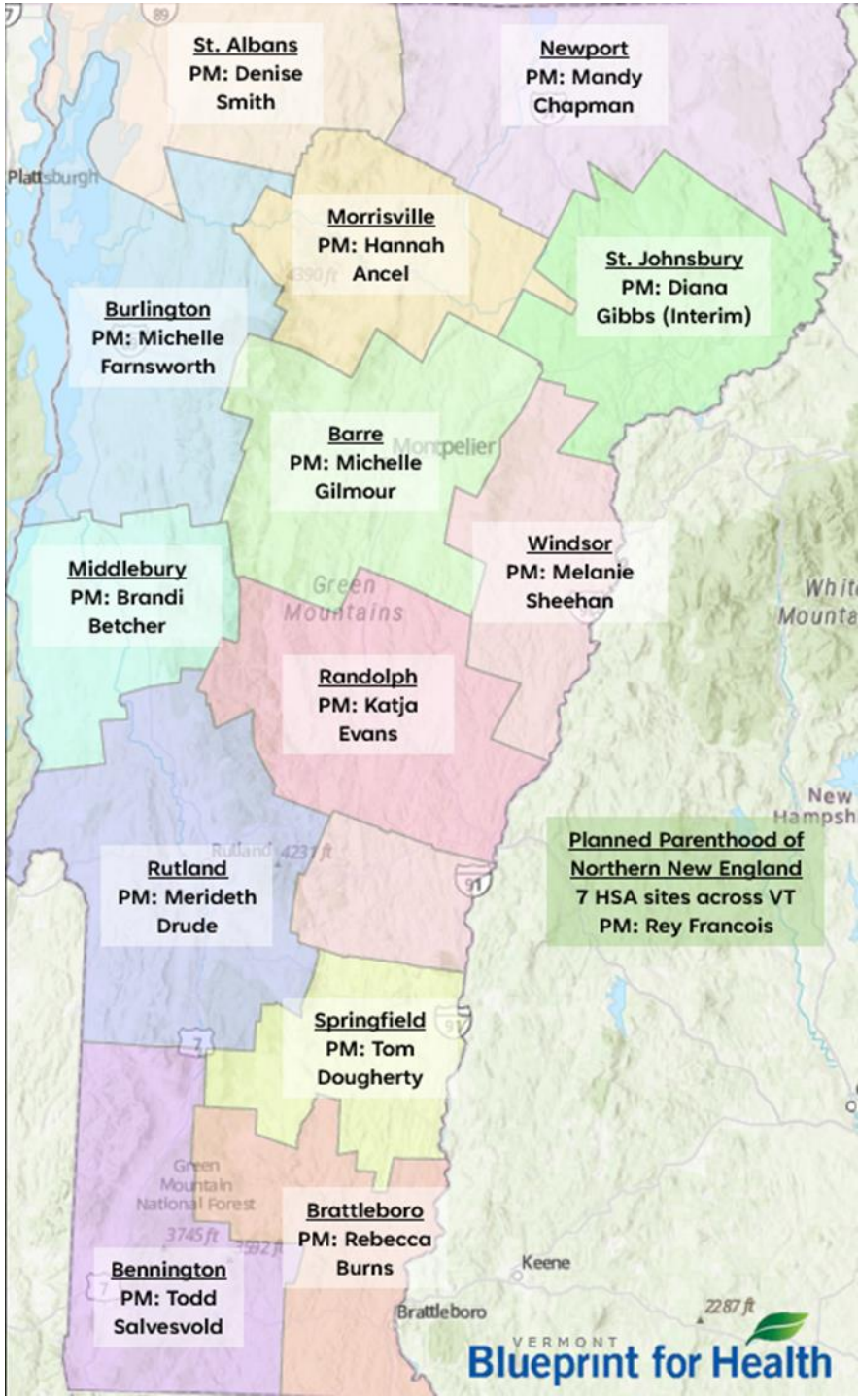
HEALTH SERVICE AREAS

ADMINISTRATIVE ENTITY

- is accountable for leading implementation 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
  - CHT/MAT leads
- Quality Improvement Facilitators



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

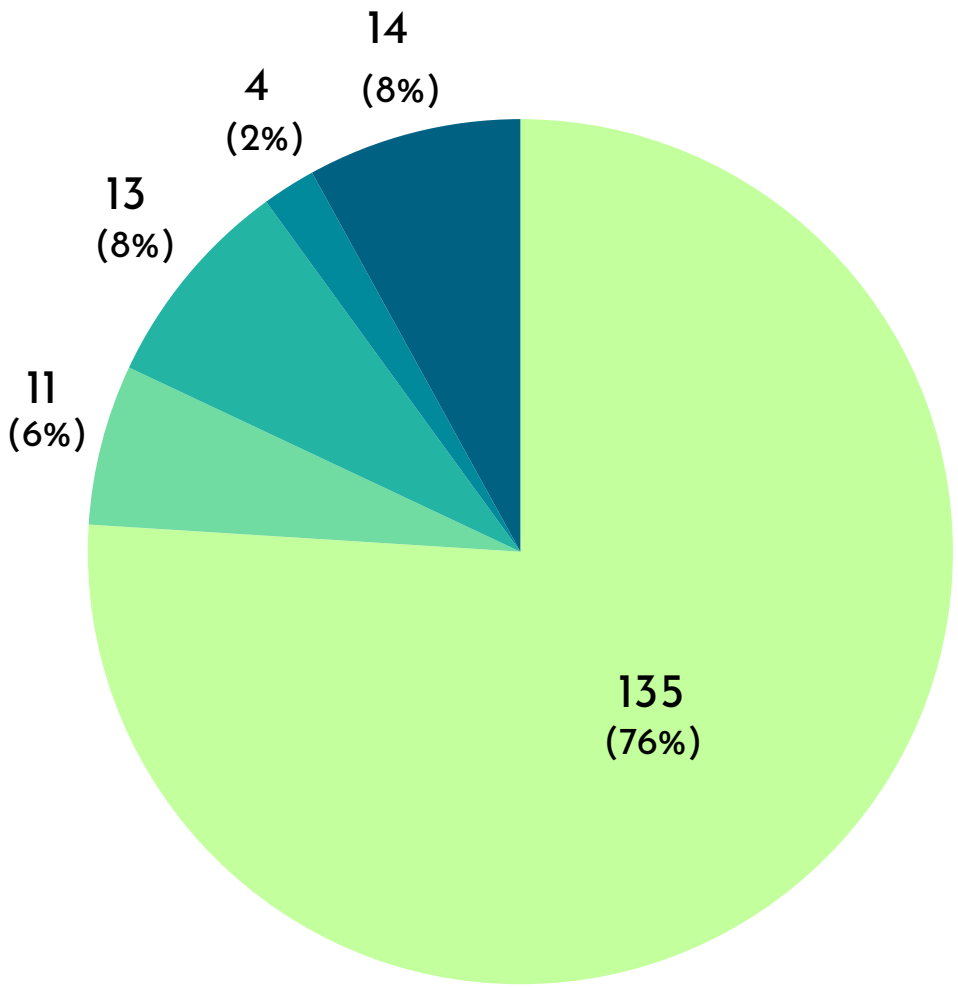
DESIGNATED MENTAL HEALTH AGENCIES

AND MANY MORE...

HOUSING

VERMONT CHRONIC CARE INITIATIVE

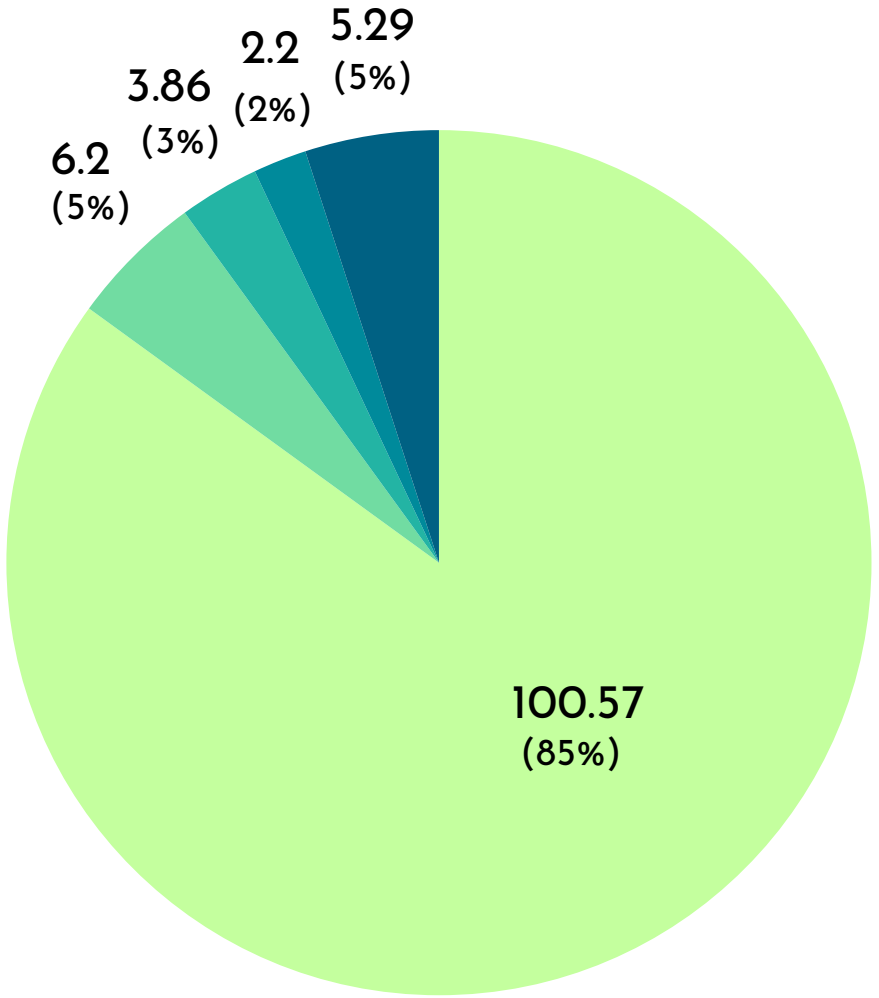
CHT Distribution by Staff



Total: 177 Staff

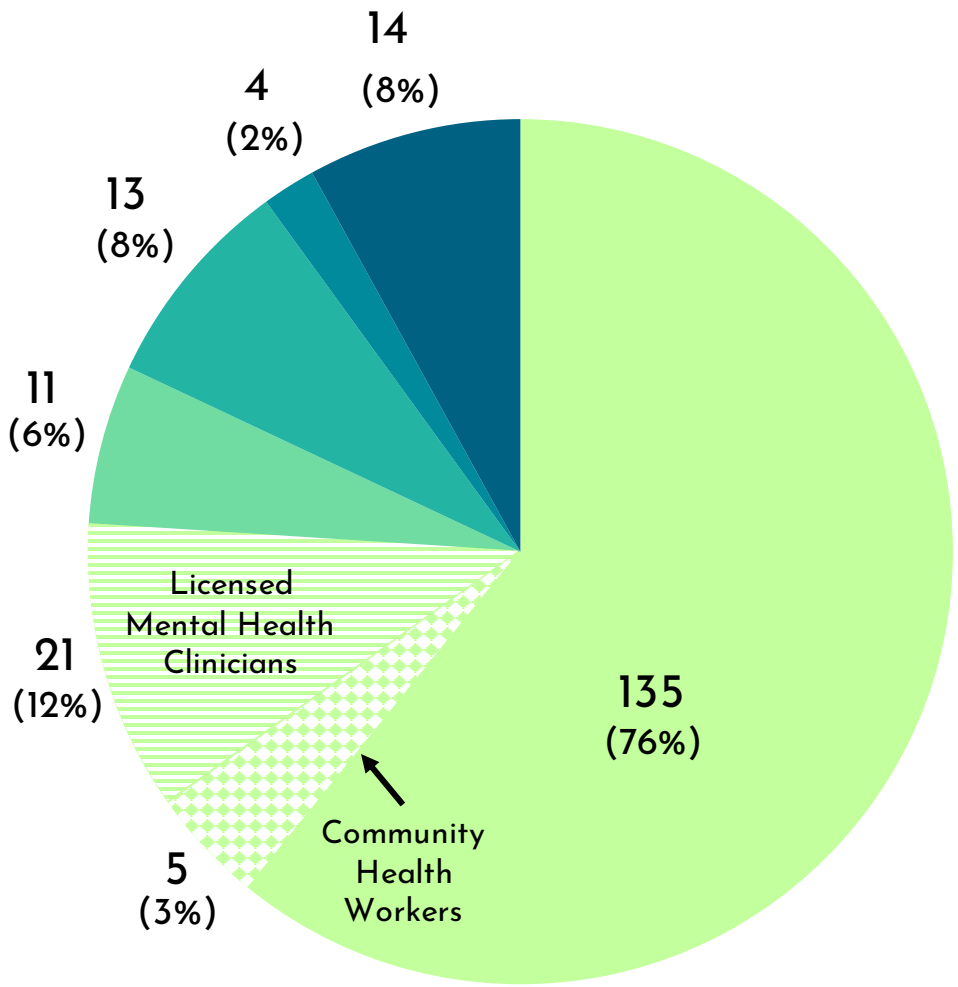
- Care Management (includes care coordination and counseling)
- Panel Managers
- CHT Oversight and Admin
- Health Educators
- Registered Dietician / Nutrition Specialist

CHT FTE Distribution



Total: 118.04 FTE

CHT Distribution by Staff



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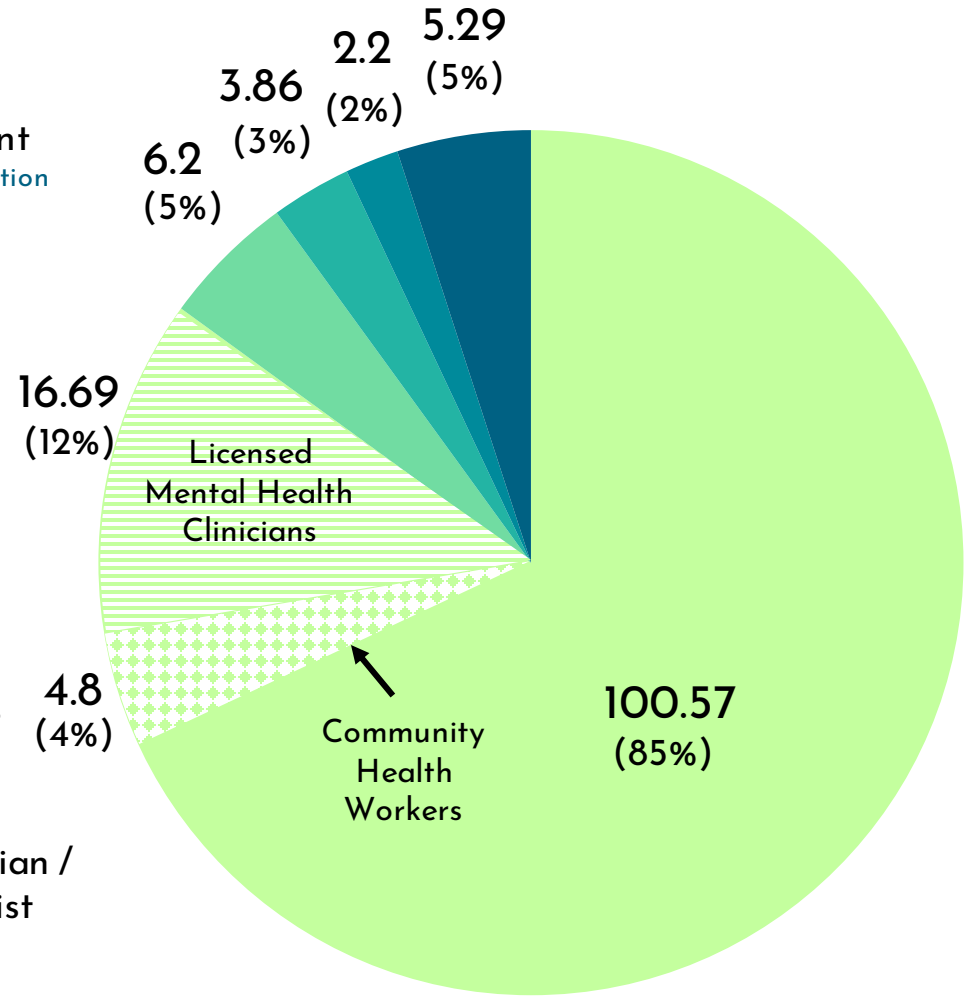

Total: 118.04 FTE

CHT Expansion

Community Health Team Staff 50-70 new staff

- Community Health Workers
- Drug and Alcohol Counselors
- Family Support Specialists
- Masters Level Mental Health Clinicians/Social Workers
  - Coordinated, Co-located, or Integrated

4 FTE QI Facilitation, which may include

- MH/SUD Physician
- Clinician
- Quality Improvement Specialist
- Project Manager

Training

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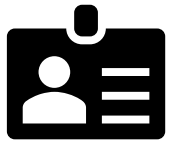
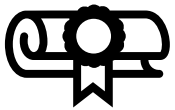
Key areas of proposal



Staff hired

Types of staff



Training sessions delivered

Motivational Interviewing

Brief behavioral change counseling

Behavioral therapy

Pharmacotherapy

Unique patients served

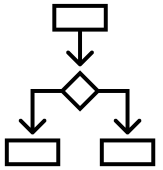
Screenings/Assessments

Care plans completed

Interventions provided

Follow ups completed

Referrals completed



QI Interventions Delivered

- In practice facilitation

- Academic detailing

- Learning collaborative

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Screening/Intervention

Needs Identification (new needs and episodes)

- Screen target population(s)
- Complete assessment
- Create individualized care plans/provide and coordinate care
- Referral Pathways

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Social Determinants of Health

Food
Housing
Inter-Partner Violence
Depression
Tobacco/ Substances

One Key Question- Pregnancy Intention

Health Related Needs in Social Settings

https://nam.edu/standardized-screening-for-health-related-social-needs-in-clinical-settings-the-accountable-health-communities-screening-tool/

Transportation
Utilities
Interpersonal Safety Family questions – HITS Hit, Insult, Threaten,Scream

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Addressing SDOH
Pediatric and Adolescent

Infants and young children (DULCE Model)

- Screening
- Referral to Services (SDOH, Legal, perinatal depression and anxiety)
- Parenting support
- 6 months-

Children and Adolescents – Discussion Who/how are screenings done

No wrong door-Accessing support

- Screening and assessment
  - Bright Futures
  - Parent screenings
  - Other

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PCMH-Adults

Stated Proposal and Legislated Requirements

Specified Measures:

- 30 day follow up after discharge from the ED for Mental Health and Substance Use Disorder
- Follow up after hospitalization for mental illness
- Initiation and engagement of substance use disorder treatment

Stepped Care (post discharge from residential or intensive outpatient treatment)

- Provide treatment plan continuity
- Support social adjustment (finances/employment, housing, food security, safety, general health status, relationships, recreational and social activities)

Continuous Care (long term relationship with PCMH)

- Addressing Relapse Risks
- Providing support for co-occurring issues and needs
- Medication Adherence
- Harm Reduction
- Self-management

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Timeline

~~***Session 1 - March 30, 2023 - Group formation, Stakeholders, Evaluation Principles***~~

Session 2 - April 13, 2023 – Understanding current structure of CHT, Goals for Expansion, Target Populations

Session 3 - April 27, 2023 – CHT staffing, Discussion of Roles, CHW, Job descriptions

Session 4 - May 11, 2023 – Screenings/Workflows

Session 5 - May 25, 2023 - Screenings/Workflows

Session 6 - May 31, 2023 – Measurement and reporting

Session 7 – June 8, 2023 – Integration/Quality improvement

Session 8 – June 22, 2023 – Open- Parking lot items

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