REPORT TO THE VERMONT LEGISLATURE

Agency of Human Services

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Annual Report on Blueprint for Health

In accordance with Act NUMBER. 18 V.S.A. § 709

Submitted to: *House Committee on Health Care,*
Senate Committee on Health and Welfare
Health Care Oversight Committee

Submitted by: Jenney Samuelson
Secretary

Prepared by: Dr. John M. Saroyan
Executive Director

Report Date: January 31, 2024

It's the Agency of Human Services' mission to improve the conditions and well-being of Vermonters and protect those who cannot protect themselves.

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I. EXECUTIVE SUMMARY

Legislation & Report Contents

18 V.S.A. § 709. requires the Blueprint for Health (Blueprint) to make an annual report to the legislature:

> *(a) The director of the Blueprint shall report annually, no later than January 31, on the status of implementation of the Vermont Blueprint for Health for the prior calendar year and shall provide the report to the House Committee on Health Care, the Senate Committee on Health and Welfare, and the Health Care Oversight Committee. (b) The report required by subsection (a) of this section shall include the number of participating insurers, health care professionals, and patients; the progress made in achieving statewide participation in the chronic care management plan, including the measures established under this subchapter; the expenditures and savings for the period; the results of health care professional and patient satisfaction surveys; the progress made toward creation and implementation of privacy and security protocols; information on the progress made toward the requirements in this subchapter; and other information as requested by the committees. The provisions of 2 V.S.A. § 20(d) (expiration of required reports) shall not apply to the report to be made under subsection (a) of this section.*

The Blueprint for Health was established to promote high quality care that integrates advanced primary care, specialty care and community-based services to impact Vermonters' health and wellbeing. Advanced primary care encompasses prevention services as well as integration of care and services for people with complex health and social needs. Supported by multi-payer participation, the Blueprint has built a foundation of advanced primary care based on the Patient-Centered Medical Home (PCMH) model and bolstered by multi-disciplinary Community Health Teams (CHTs) that provide care coordination and linkages to services across the care continuum and in the community. Essential to the success of the PCMHs and CHTs is a network of locally hired Program Managers, Community Health Team Leaders, and Quality Improvement Facilitators. This network has been integral to facilitating local transformations and increasing collaboration across community partners.

Building on the PCMH and CHT model, the Blueprint program has expanded to include the Hub and Spoke System of Care for individuals with opioid use disorder and specifically supports primary care practices providing medication for opioid use disorder. The Blueprint also created the Women's Health Initiative (renamed Pregnancy Intention Initiative), to ensure access to services that support pregnancy intention. In 2023, the Blueprint program was further expanded to include a CHT Expansion Pilot Program to address mental health, substance use disorder, and social determinants of health within primary care.

Program Evolution

Act 78 of 2023 provided two years of funding for several pilot projects targeted at the expansion of health services related to mental health and substance use in Vermont, including expansions of the Blueprint for Health's CHTs and the Health Department's Hub opioid use treatment centers and Developmental Understanding and Legal Collaboration for Everyone family specialist program. In close coordination with the Secretary, Department of Health, Department of Mental Health, Department of Vermont Health Access and Director of Health Care Reform, the Blueprint staff convened workgroups and scheduled stakeholder meetings to develop the CHT Expansion Pilot. The result was a recommendation for payments to CHTs so that Health Service Area Administrative Entities can expand vital services to address the mental health and substance use needs of the population in an integrated way.

Patient-Centered Medical Homes

The PCMH is a model of care that has transformed how primary care is organized and delivered in Vermont. There are currently 131 participating primary care practices in this initiative representing close to 90% of known primary care practices operating in Vermont. Of these practices, 130 have sustained National Committee of Quality Assurance (NCQA) PCMH recognition from previous years and one newly opened practice is working towards achieving this recognition. Participation of practices in the PCMH program has remained relatively stable over the last five years, with small amounts of attrition occurring annually due to retirements or consolidations, and small increases due to newly opened practices or acquisitions.

Community Health Teams

Along with the PCMH model, CHTs are integral to the success of the Blueprint. These teams, funded by commercial and public payers, provide services to patients that are not generally covered by insurance. Services can include care coordination, social work, brief mental health interventions, referrals to services, and numerous other interventions, free of charge and without regard to insurance status. Currently, there are a total of 223 staff (151 full-time equivalent staff) working as members of the CHTs across the state. These positions include nurses, social workers, mental health counselors, health educators, registered dietitians, community health workers, panel managers, and others who work to provide whole person care for Vermonters.

The Blueprint tracks the numbers of patients served by CHT staff, including their insurance type where possible. This information indicates that CHTs serve individuals with a variety of insurance types, highlighting the importance of the Blueprint's universal approach. In 2023, practices continued to build the capacity to track patients, encounters, and payers without compromising patient confidentiality.

Hub and Spoke

Hub & Spoke is Vermont's system of medication for opioid use disorder support for people in recovery from opioid use disorder. The Blueprint administers the Spoke part of the Hub & Spoke system while the Department of Health administers the Hubs. Vermont continues to demonstrate substantial access to medication-assisted treatment for Vermonters with opioid use disorder by providing registered nurses, and licensed, Master's-prepared, mental health/substance use disorder clinicians as a team to offer evidence-based treatment and provide Health Home services for Vermonters with opioid use disorder.

Pregnancy Intention Initiative (Formerly Women's Health Initiative)

The Pregnancy Intention Initiative (PII) strives to support any persons who can become pregnant in their efforts to experience healthy pregnancies, avoid unintended pregnancies, and build thriving families. The PII provides increased mental health staffing at specialty practices and utilizes the existing CHT at Blueprint PCMH practices. If a patient identifies as needing support they have access to a mental health clinician for brief interventions, counseling, and navigation to community-based services and treatment as needed. See below for further explanation of the name change.

Self-Management Programming

The Blueprint and the Vermont Department of Health maintain a Memorandum of Understanding to work closely together for the provision of Self-Management Programming through My Healthy Vermont workshops. While the Blueprint still provides the funding and oversight of the programming, the Health Promotion and Disease Prevention (HPDP) unit within the Department of Health administers the programs through grants to local hospitals and Federally Qualified Health Centers. This partnership takes advantage of the additional funding and content expertise that exists within HPDP through the My Healthy Vermont program, and pairs it with Blueprint's influence at the local level.

From October 2022 through September 2023, the Department of Health and the Blueprint offered 100 workshops, with a total of 435 individuals completing a program. The Diabetes Prevention Program and the Blood Pressure Management Program had the largest numbers of workshop completers.

Evaluation

Population health measures for CY 2021 are beginning to show a return to pre-pandemic levels in many areas of screenings, well visits, and specialist and primary care encounters. Inpatient hospital stays, potentially avoidable emergency department visits, and overall health care expenditures are still showing lower rates post-pandemic.

In June of 2023, the Blueprint received an extract of claims data for the fiscal years ending in 2019, 2020, 2021, and 2022. This data was categorized in multiple ways, including a breakdown between patients attributed to Blueprint affiliated PCMH practices and those attributed to other primary care practices. The dataset also included an attribution of individuals to a Mental Health and Substance Use (MH/SUD) category if the individual had at least two outpatient claims or one inpatient claim with specific diagnosis codes. Analysis of this data resulted in several valuable insights regarding the state of health care in Vermont and the effectiveness of the Blueprint's initiatives. Details on this analysis are available in Section D.

Additionally, the Blueprint reports annually patients' experience of care as required by Vermont statute. Since 2011, this task has been fulfilled through the administration of the Consumer Assessment of Healthcare Providers Survey (CAHPS) for Clinicians and Groups with PCMH questions included. The results of this survey provide the broadest statewide look at patient experience of primary care in Vermont. The results are also used to support PCMH recognition by NCQA, and, most recently, as part of the quality reporting under payer contracts with OneCare Vermont under the All-Payer Accountable Care Organization Model.

Health Service Areas (HSAs)

The Blueprint staff in each HSA are responsible for the continued success of the program and have worked during 2023 to address the ongoing needs of their communities. Section V of this report includes in-depth information provided by each HSA, such as details about CHT staffing and structure, community health priorities and special projects, and other details that describe the important work of the Blueprint field teams.

II. INTRODUCTION

The Vermont Blueprint for Health (Blueprint) was established to promote high quality primary care that is integrated with services outside of the medical setting that affect health and wellbeing. Supported by multi-payer participation, the Blueprint has built a foundation of primary care based on the Patient-Centered Medical Home (PCMH) model[1] and bolstered by multi-disciplinary Community Health Teams (CHTs) that provide care coordination and linkages to services across the care continuum. Essential to the success of the PCMHs and CHTs is a network of locally hired Program Managers, CHT Leaders, and Quality Improvement (QI) Facilitators. This network has been integral to facilitating local transformations and increasing collaboration across community partners[2].

Building on the PCMH and CHT model, the Blueprint program has expanded to include the Hub and Spoke System of Care for individuals with opioid use disorder and specifically supports primary care and specialty practices providing medication for opioid use disorder. The Blueprint also created the Women's Health Initiative, renamed the Pregnancy Intention Initiative (PII), to ensure access to services that support pregnancy intention. In 2023, the Blueprint program was further expanded to include a CHT Expansion Pilot Program to address mental health, substance use disorder, and social determinants of health within primary care.

While the program has evolved beyond the original "chronic care management plan" described in legislation, it remains true to the original vision of all-payer supported, community-directed health reform that promotes the health of all Vermonters. This report describes the activities and progress of the Blueprint during 2023.

A. Executive Committee

The Blueprint for Health statute defines the membership and role of the Blueprint Executive Committee as an advisory body for the Executive Director. The Blueprint Executive Committee is currently complete with assigned members representing each of the required stakeholders. The committee met 8 times in 2023, providing guidance and input for all Blueprint proposals and analyses. The minutes and materials for each meeting can be found on the Blueprint website.

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[1] The National Committee on Quality Assurance (NCQA) sets standards around the following elements of the PCMH model: 1) team-based care; 2) understanding and managing patient needs; 3) patient-centered access and continuity; 4) care management protocols; 5) care coordination and transition protocols; and 6) continual performance measurement and quality improvement. https://www.ncqa.org/wp-content/uploads/2019/06/06142019_WhitePaper_Milliman_BusinessCasePCMH.pdf

[2] Community Partners include home health agencies, mental health agencies, developmental disability service providers, emergency medical service providers, adult day service providers, area agencies on aging, transportation services, foodbanks, and community action agencies.

B. Program Evolution: Community Health Team Expansion Pilot

Act 78 of 2023 provided two years of funding for a pilot project targeted at enhancing health services related to mental health and substance use in Vermont through expansion of the Blueprint for Health's CHTs, including Developmental Understanding and Legal Collaboration for Everyone (DULCE) family specialist program. Act 78 also expanded funding for the Health Department's Hub opioid use treatment centers.

In close coordination with the Secretary, Department of Health, Department of Mental Health, Department of Vermont Health Access and Director of Health Care Reform, the Blueprint staff convened workgroups and scheduled stakeholder meetings to develop the CHT Expansion Pilot. The result was a recommendation for payments to CHTs so that Health Service Area Administrative Entities can expand vital services to address the mental health and substance use needs of the population in an integrated way. Expanded CHTs include additional staff serving as Community Health Workers, Mental Health Counselors, and Social Workers, and an addition of Family Specialists to serve in a pediatric or family medicine primary care practice with the DULCE model.

1. Community Health Team Expansion

The Blueprint created three implementation workgroups—Program Design, Measurement and Evaluation, and Payment—consisting of key stakeholders throughout the state. These workgroups met virtually throughout the spring and summer and helped to determine both overall direction and focus of the Pilot as well as specific implementation goals and targets. Information about the Blueprint CHT Expansion Pilot can be found here, including slides, presentations, workgroup materials, and meeting minutes.

Practices were required to submit an attestation form to indicate their participation in the CHT Expansion Pilot. As of December 1, 2023, a total of 113 practices (representing 86% of PCMHs in Vermont) have submitted attestations to participate in this pilot.

At the end of October 2023, a survey was distributed to all Blueprint for Health PCMHs to collect information about Expansion Pilot implementation progress. A total of 48 responses were received (representing more than 70 practices). Most of these practices indicated that they were in the planning and job description and posting creation stage of implementation at the time of the survey.

Positions that are filled using CHT Expansion funding are tracked centrally; as of December 1, 2023, a total of 18.21 full-time equivalent staff positions have been hired using available pilot funding.

All practices participating in the CHT Expansion Pilot engaged in chart review to establish baseline understanding of screening patterns, how patients are identified for CHT services, CHT interventions provided, and CHT support for navigation to services. Evaluation data was also collected in the CHT Expansion Practice and Provider Survey regarding

acceptability of CHT services to providers and patients. Detailed results of the Chart Review and Provider/Practice Survey will be available in the first quarter of 2024.

The Blueprint for Health is increasing the number of supports available to practices for implementation, training, quality improvement, and evaluation. Contracts are in the final stages or have been executed for Specialized QI Facilitators and training providers. The central office surveyed the field on training needs and facilitated one work group to discuss findings from the survey. Key training areas requested by the field include motivational interviewing, diversity/equity/inclusion, social determinants of health, and the role of Community Health Workers. The central office will also engage with Agency of Human Services teams to support team-based care in each Health Service Area with community partners to support patients with complex medical and social needs.

2. Developmental Understanding and Legal Collaboration for Everyone

Vermont's Developmental Understanding and Legal Collaboration for Everyone (DULCE) program is overseen by the Vermont Department of Health (VDH) Division of Family and Child Health with the approach's required Continuous Quality Improvement led by the Vermont Child Health Improvement Program (VCHIP) at the University of Vermont. VDH and Blueprint work collaboratively to achieve DULCE implementation through the CHTs, including partnering on sustainability and expansion planning for DULCE Family Specialists to serve the needs of infants 0-6 months as well as the needs of children up to age 5 in pediatric practices. A total of $913,600.00 dollars has been included to support embedding Family Specialists at six sites, including five sites currently engaged with DULCE and an additional sixth primary care site. Funding for Family Specialists will be delivered to the relevant Administrative Entity, with the Blueprint Program Manager working closely with the local Parent Child Center to hire and support the Family Specialist in the HSA.

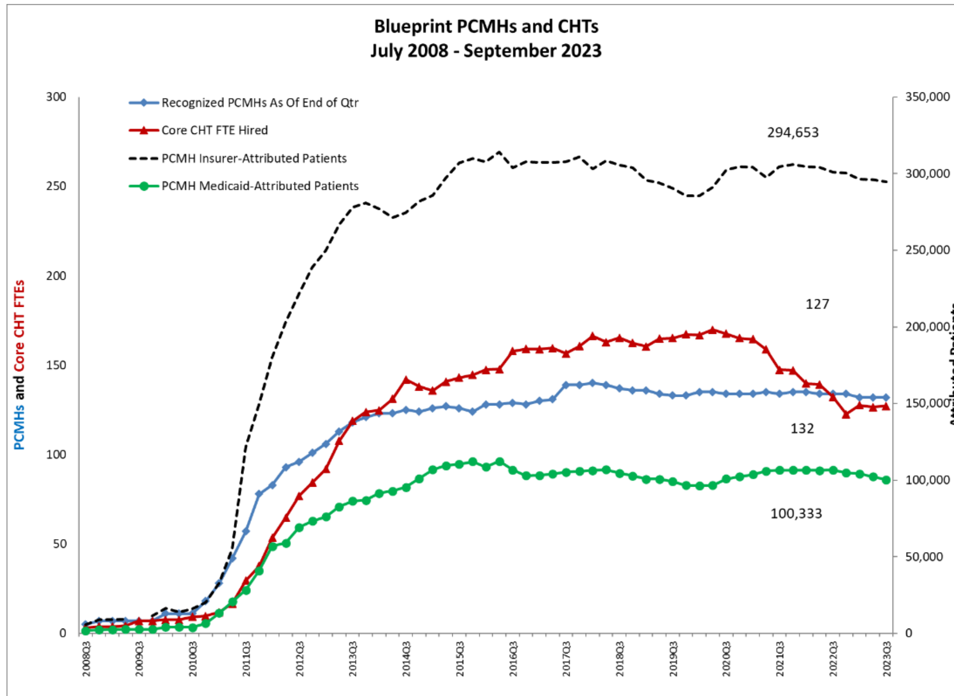
The Blueprint has created a Memorandum of Understanding with VDH to support Family and Child Health in building a pediatric model that will take components of the DULCE approach and extend this beneficial work beyond six months of age to provide universal screening, referrals, and supports to practices that serve families with children ages 0-17.

3. Community Health Team Expansion Pilot Evaluation

Contracting is in progress for a qualitative and quantitative evaluation of the Blueprint CHT Expansion Pilot. Contractors will provide outside evaluation of the Expansion Pilot initiative, including historical overviews of relevant data.

III. PROGRAMMATIC UPDATES

1. Patient-Centered Medical Homes



The Patient-Centered Medical Home (PCMH) is a model of care that has transformed how primary care is organized and delivered in Vermont. Delivering this model of care means:

- clinician-led teams coordinate care, especially for disease prevention and chronic condition management;
- Medical Homes coordinate with other care providers and community resources; and
- all members of the Medical Home team are committed to improving patient experience of care, health outcomes, and overall value of care.

Vermont selected the National Committee for Quality Assurance (NCQA) PCMH recognition model in 2008, which is now the most widely adopted PCMH evaluation program in the country.

In 2023, practices that were recognized PCMHs provided evidence and/or attestation that they:

- clearly define practice leadership organization, care team responsibilities, and protocols for how the practice partners with patients, families, and caregivers;

- meet standards for data collection, medication reconciliation, evidence-based clinical decision support, and other activities;
- follow care management protocols to identify patients who need more closely managed care;
- maintain systems and protocols for information sharing and management of patient referrals between primary care and specialty care practices; and
- implement processes and practices for performance measurement, goal setting, and ongoing participation in quality improvement activities.

One practice initiated a new transformation into a PCMH in 2023. Three other previously recognized practices changed organizational affiliation or had a substantial enough change in location, population served, or providers employed to require that they were required to undergo a more substantial review process with NCQA.

One hundred twenty-eight (128) practices sustained recognition as a PCMH in 2023 by attesting that they meet the core requirements and providing additional evidence required for annual reporting. Typically, these practices began active preparation work six to nine months ahead of their anniversary date, working on ensuring that they understood any new standard requirements, were sufficiently able to provide the required evidence for standards that must be reported on an annual basis (e.g. medication reconciliation rates), and selected and worked on a minimum of six quality improvement projects across the domains of clinical quality measures, resource stewardship measures, appointment availability, and patient experience of care. Five of these practices were randomly selected for an in-depth NCQA audit in 2023, although one was given an exemption from this audit due to timing coinciding with the catastrophic floods that affected the practice in July 2023. Four recognized practices closed in 2023 due to retirement and consolidation.

This evolution of the recognition process has allowed for a greater focus on continuous quality improvement work in the practice while continuing to raise the quality standard of care in PCMHs. Practices are currently preparing to meet new standard requirements for 2024 related to electronic health record utilization and standardized measure reporting.

With more than a decade of support for primary care through the PCMH initiative, Vermont is well poised for embracing novel federal models focused on primary care quality and investment.

QUALITY IMPROVEMENT FACILITATION

The Blueprint currently offers participating practices the services of a Quality Improvement (QI) Facilitator to support practices to improve the care they deliver, by focusing on implementation of evidence-based care or models of care to improve patient outcomes and experiences. QI Facilitators are highly skilled in quality planning (using data, feedback from patients, community members, employees, and other key stakeholders to guide strategy) and continuous quality improvement (applying the science of improvement to achieve desired aims and address performance).

Presently, there are twelve general QI Facilitators assigned to work with Blueprint participating practices in a geographic area, and one specialized QI Facilitator working across the State. General QI Facilitators are considered local experts in the PCMH Model and coach practices to achieve and retain NCQA recognition. These facilitators work on an ongoing basis to support continuous quality improvement activities within their practices and regions and assist with quality improvement efforts related to panel management and outreach, care coordination, promotion of individual health and wellness, chronic condition management, and ongoing value-based care transformation in alignment with state-led health care reform priorities.

The specialized QI Facilitator will be developing quality tools and resources for the Community Health Team Expansion Pilot, working directly with practices who will engage in provider coaching and/or academic detailing interventions, coordinating expansion pilot learning collaboratives, and supporting quality improvement efforts that bridge PCMHs, hospitals, specialty mental health and substance use providers, and community service organizations.

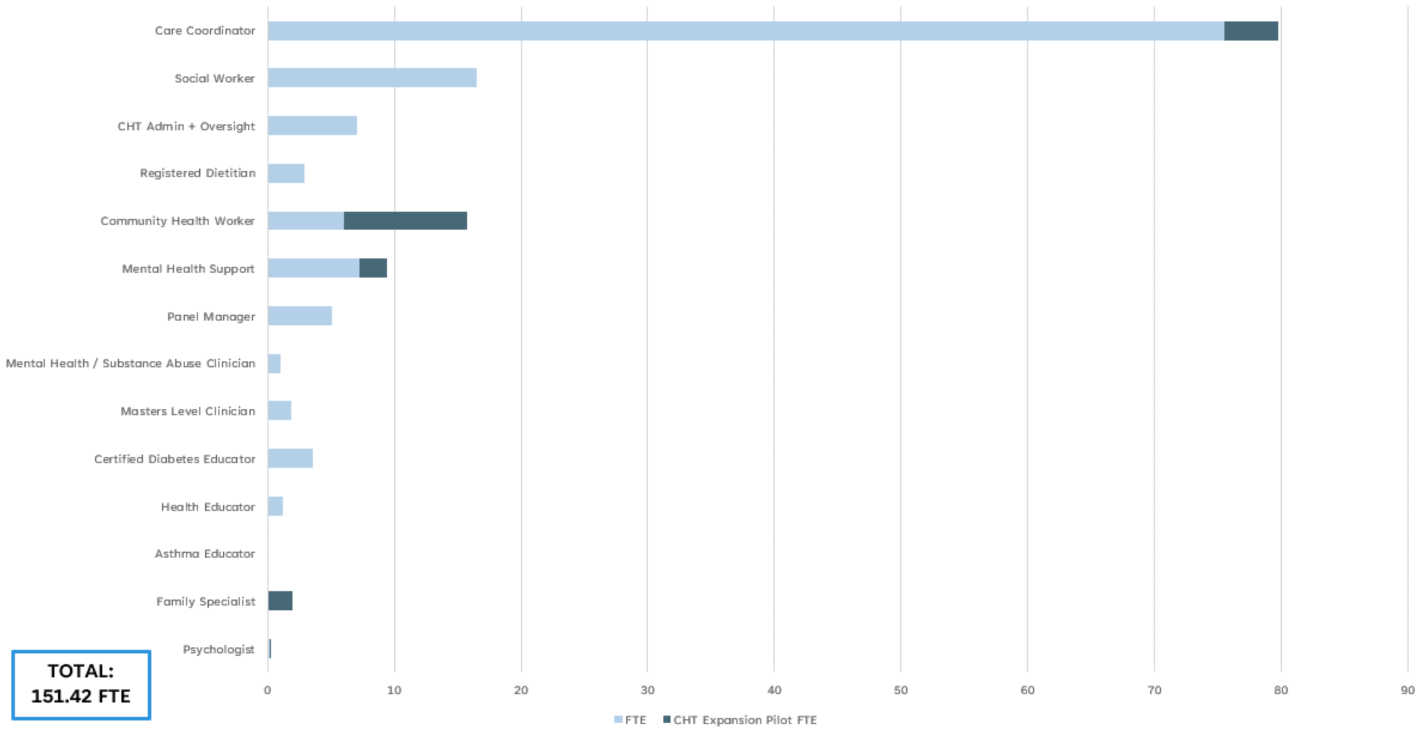
Both general and specialized QI facilitators provide support to practices for implementation and quality improvement efforts related to enhanced mental health/substance use/social determinants of health screening, further integration of mental health and substance use CHT services in PCMHs, and care coordination across the spectrum of medical and social service providers as a component of the CHT Expansion Pilot.

In partnership with the Care Transformation Collaborative of Rhode Island, all facilitators will receive training on the core competencies of mental health and substance use integration facilitation in primary care settings in early 2024.

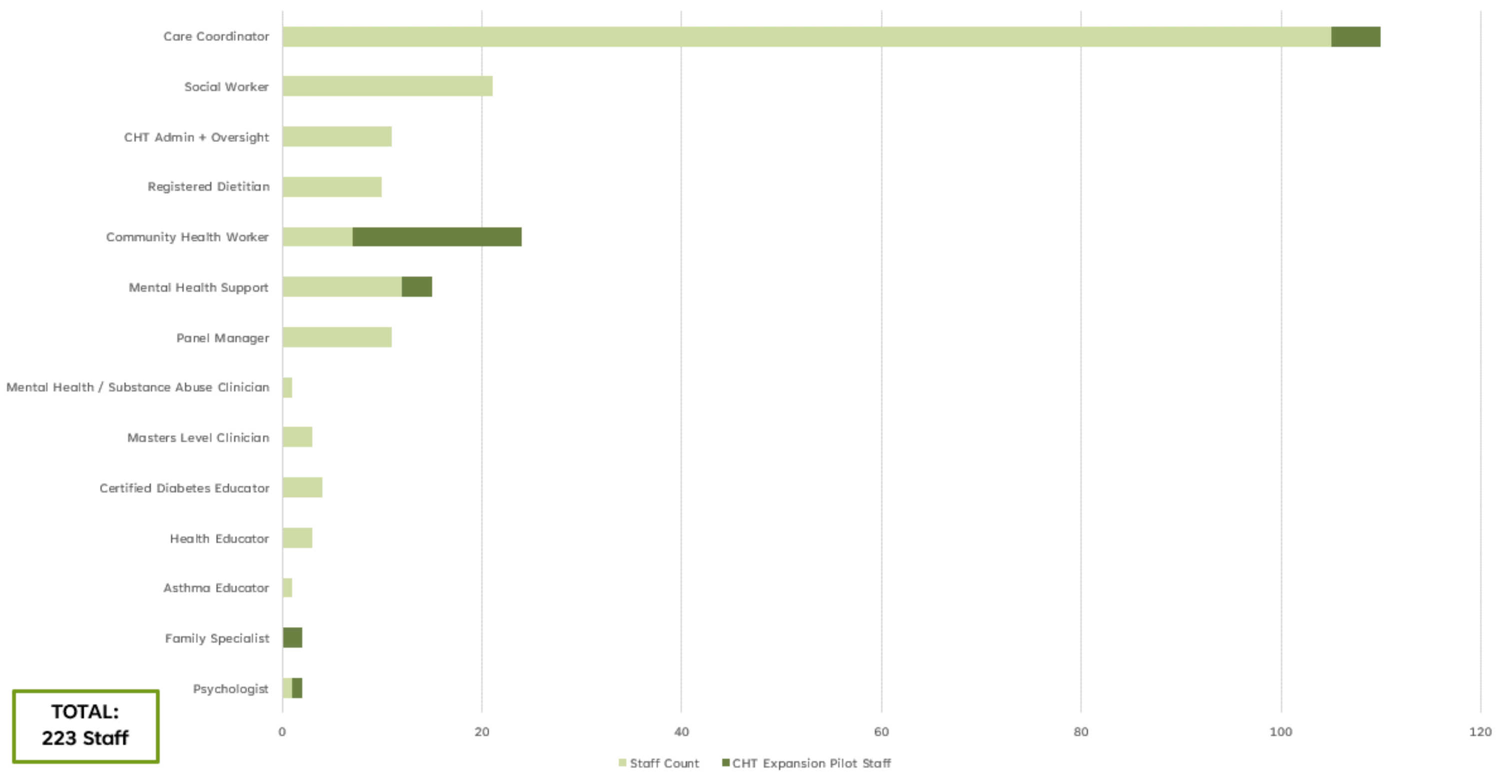
2. Community Health Team Data

Along with the PCMH model, CHTs are integral to the success of the Blueprint. These teams, funded by commercial and public payers, provide services to patients that are not generally covered by insurance. A CHT member can provide screening, brief intervention, referral to treatment, care coordination, and self-management support, among other interventions. The Blueprint strives to provide person-centered care to all Vermonters. It is essential that

the CHT work with community partners as a team to support patients as part of each person's care plan, especially those with complex physical and social needs. These services are provided free of charge and without regard to insurance status. The types and distribution of CHT staff members in 2023 is highlighted on the following page. The graphs show the immediate impact of the CHT Expansion Pilot on increasing staff in critical areas. Evaluation of the impact of the Pilot will proceed as the CHT Expansion Pilot continues through its first and second years.

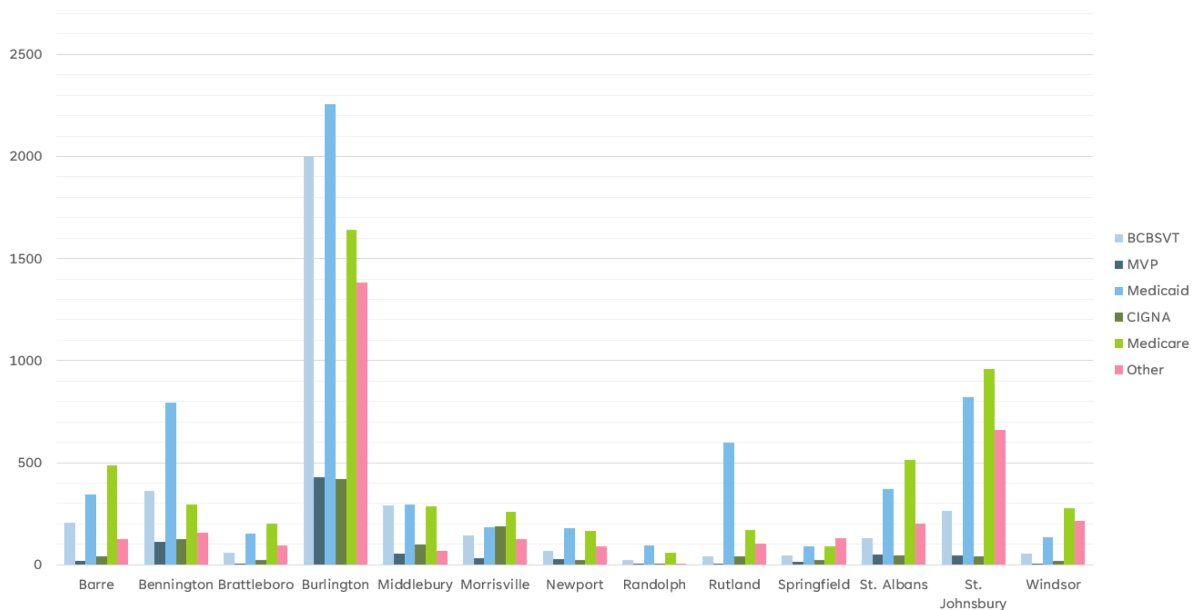


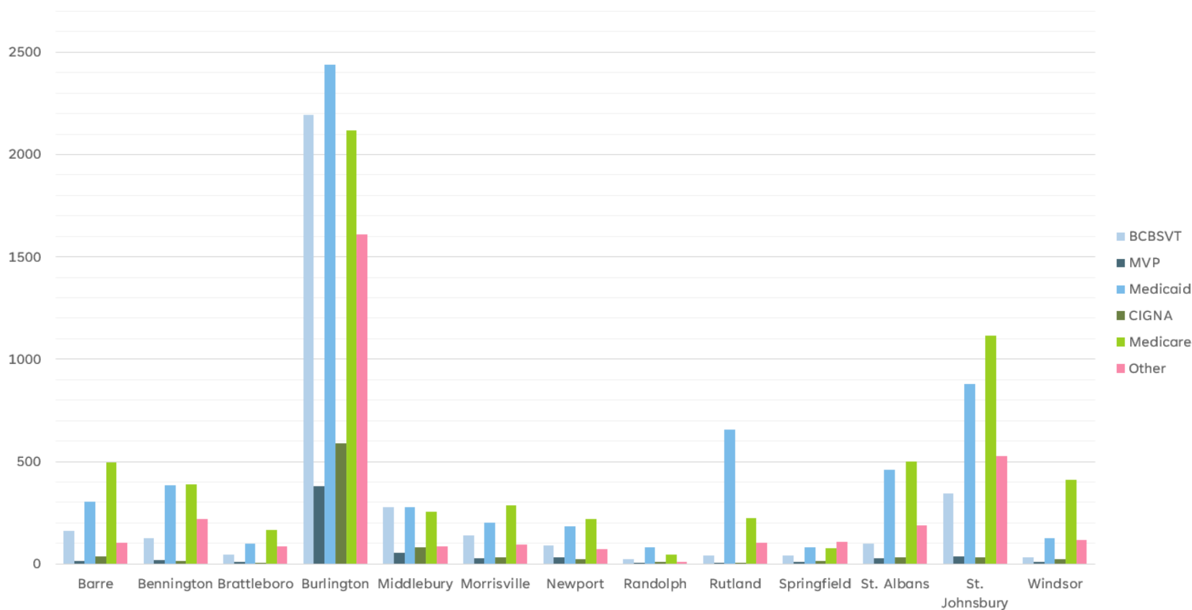
TOTAL: 151.42 FTE

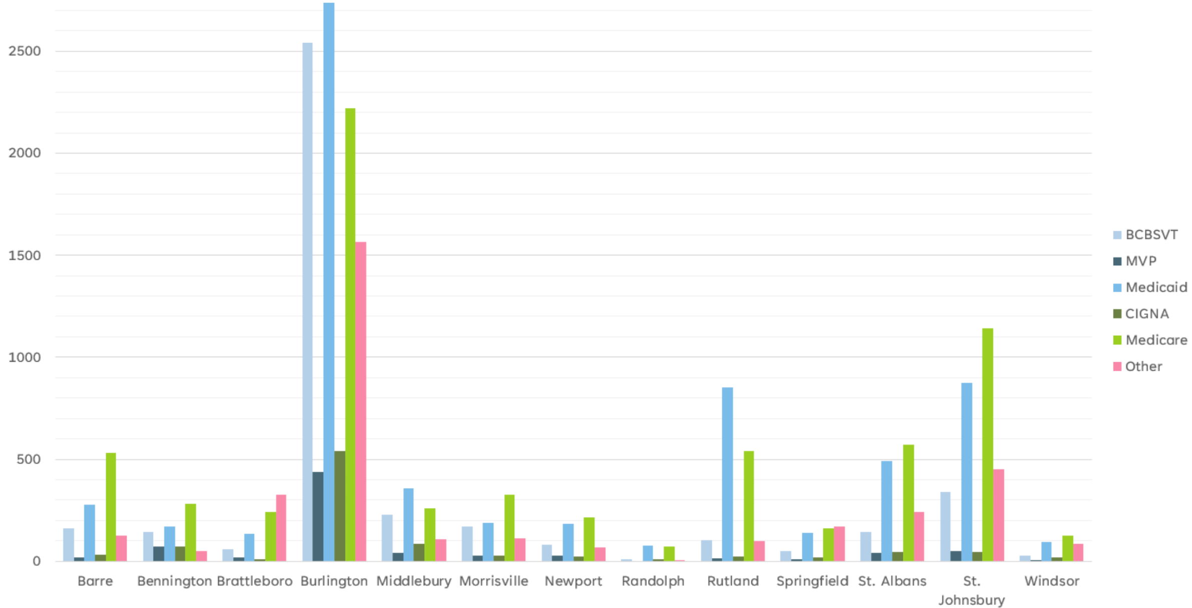


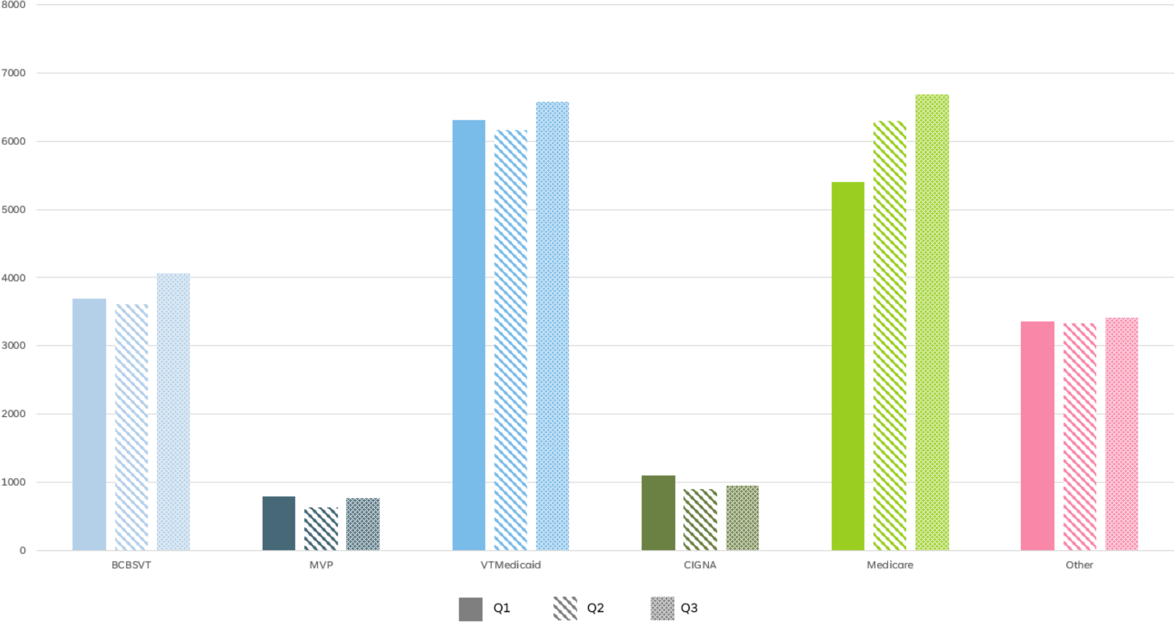
TOTAL: 223 Staff

During 2022, the Blueprint began to track the numbers of patients served by CHT staff, including their insurance type where possible, for the first time. This information indicated that Community Health Teams serve individuals with a variety of insurance types, highlighting the importance of the Blueprint's universal approach. The Blueprint will continue to build the capacity to track patients, encounters, and payers without compromising patient confidentiality.




Blueprint Community Health Team Patients by Payers
CY April - June 2023 Q2
2500
2000
1500
1000
500
0
Barre
Bennington
Brattleboro
Burlington
Middlebury
Morrisville
Newport
Randolph
Rutland
Springfield
St. Albans
St. Johnsbury
Windsor
BCBSVT
MVP
Medicaid
CIGNA
Medicare
Other


Blueprint Community Health Team Patients by Payers
CY July – September 2023 Q3
2500
2000
1500
1000
500
0
Barre
Bennington
Brattleboro
Burlington
Middlebury
Morrisville
Newport
Randolph
Rutland
Springfield
St. Albans
St. Johnsbury
Windsor
BCBSVT
MVP
Medicaid
CIGNA
Medicare
Other


Statewide Totals – BP CHT Patients by Payers
CY 2023 Q1 – Q3
8000
7000
6000
5000
4000
3000
2000
1000
0
BCBSVT
MVP
VTMedicaid
CIGNA
Medicare
Other
Q1
Q2
Q3

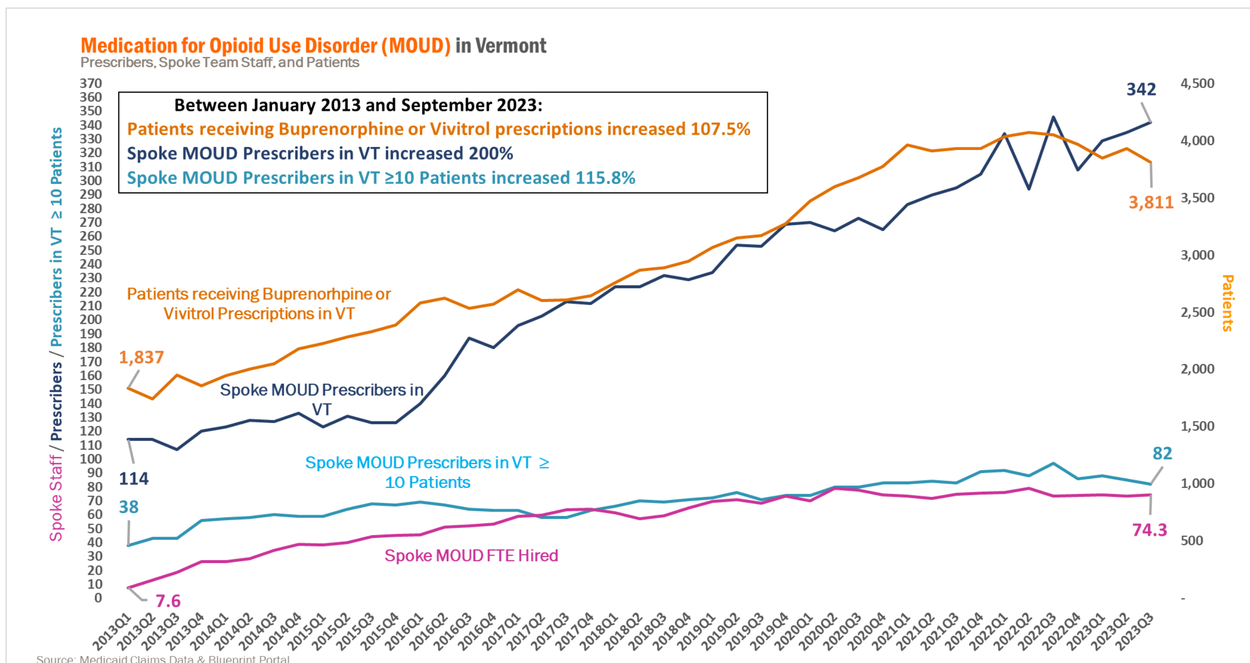
3. Hub & Spoke

Hub & Spoke is Vermont's system of medication for opioid use disorder (MOUD) supporting people in recovery from opioid use disorder (OUD). The Department of Health and the Blueprint for Health have been longstanding partners to support Vermont's Hub and Spoke providers, partners, and provider leaders together to share expertise and continue to improve the quality of care in the system.

The Blueprint administers the Spoke part of the Hub & Spoke system of care, while the Department of Health administers the Hubs. For every 100 Medicaid patients that are prescribed buprenorphine or vivitrol, the Blueprint supports communities to hire a full-time nurse and mental health clinician.

The Blueprint contracted with the Center for Technology and Behavioral Health at Dartmouth College for Medication Assisted Treatment Learning Collaboratives provided to the Hub & Spoke Opioid Use Disorder care network. The curriculum, delivered from January through June 2023, included six virtual monthly events. Three webinars featured national presenters and three virtual workshops featured Vermont-based content experts and sessions alternated between didactic care management webinars and multidisciplinary care management workshops. An average of 49 OUD care specialist nurses or mental health clinicians attended each event.

Vermont continues to demonstrate substantial access to MOUD by funding registered nurses and licensed, Master's-prepared, mental health/substance use disorder clinicians as a team. These Spoke teams offer evidence-based treatment and provide Health Home services for Vermonters with opioid use disorder. The Blueprint continues to encourage the use of VT Help link, a free and confidential referral service available to connect people to resources and treatment (802-565-LINK or Vermont Help Link).

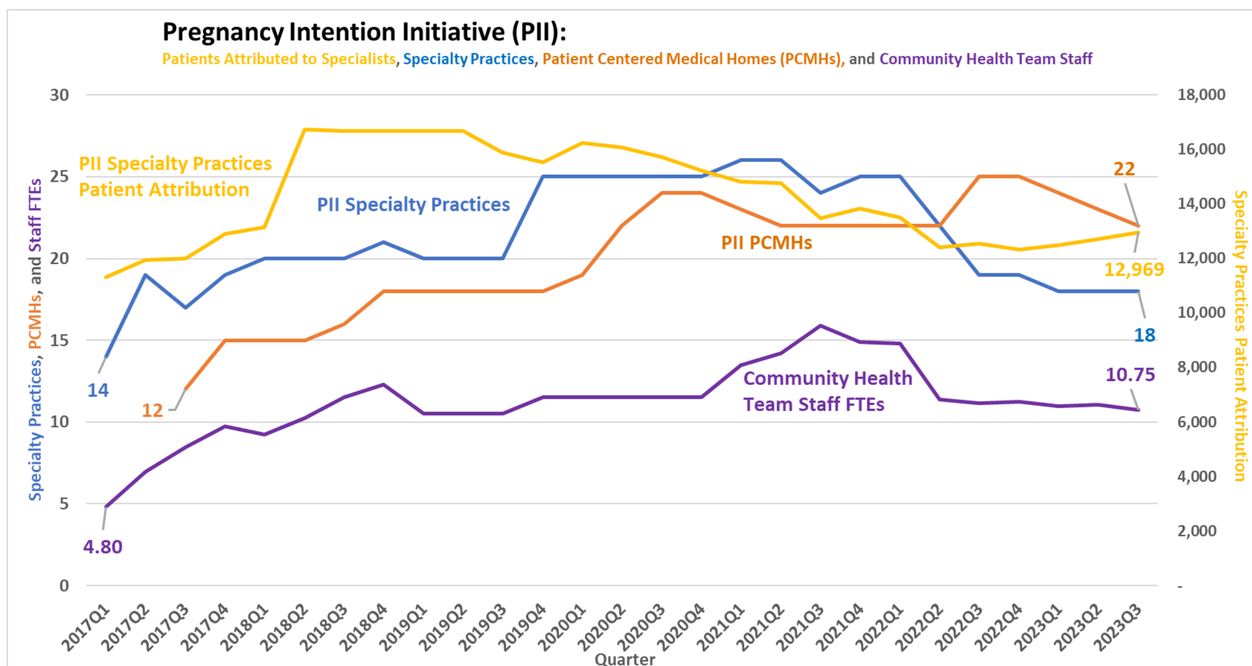


4. Pregnancy Intention Initiative (formerly Women's Health Initiative)

The Women's Health Initiative (WHI) has strived to support people who can become pregnant in their efforts to experience healthy pregnancies, avoid unintended pregnancies, and build thriving families. This year the Women's Health Initiative program changed its name to the Pregnancy Intention Initiative (PII) to focus on being more inclusive for transgender and non-binary patients. The Blueprint surveyed the field and held focus groups to gather input on the name change.

The PII provides mental health staffing at specialty practices and utilizes the existing CHT at participating Blueprint PCMH practices. Practices attest to support the goals of PII. People with a desire to become pregnant or prevent pregnancy can receive services to support decision making. If an individual would like to prevent pregnancy, providers conduct comprehensive family planning counseling and provide patients with options for most and moderately effective contraception, which could include access to same-day long-acting reversible contraceptives (LARC) if clinically indicated. If a person would like to become pregnant, they receive support for a healthy pregnancy. The practice screens for social determinants of health such as food security, housing security, interpersonal violence, depression, anxiety, harm to self or others, mental health issues, and substance use. Positive screens are addressed with brief interventions and treatment by the embedded PII mental health clinician if indicated. These clinicians also communicate programmatic information to community partners to build meaningful relationships, support patients more closely, and create seamless transitions of care when referral is necessary.

In 2023, the Blueprint reinstated quarterly in-person hands-on trainings to support the PII network of providers in contraceptive care. In collaboration with the University of Vermont, Dr. Lauren MacAfee trained more than 50 providers this year from Blueprint PII sites in LARC insertion and best practices around patient choice of contraception in the past year. The community providers requested further training and support for individuals who want to increase comfortability and knowledge in gender-affirming care. In January, the Area Health Education Centers and University of Vermont Project Echo began supporting the network and provided six monthly trainings for clinicians in gender-affirming care.



5. Self-Management Programming

The Blueprint and the Vermont Department of Health maintain a Memorandum of Understanding to work closely together for the provision of Self-Management Programming through My Healthy Vermont workshops. While the Blueprint still provides the funding and oversight of the programming, the Health Promotion and Disease Prevention (HPDP) unit within the Department of Health administers the programs through grants to local hospitals and Federally Qualified Health Centers (FQHCs). This partnership takes advantage of the additional funding and content expertise that exists within HPDP through the My Healthy Vermont program, and pairs it with Blueprint's influence at the local level.

Health Service Areas offered six types of Self-Management Programs during 2023:

- Blood Pressure Management

- Chronic Disease Management
- Chronic Pain Management
- Diabetes Self-Management Program
- Diabetes Prevention Program
- Quit Smoking

From October 2022 through September 2023, the Department of Health and the Blueprint offered 100 workshops, with a total of 435 individuals completing a program. The Diabetes Prevention Program and the Blood Pressure Management Program had the largest numbers of workshop completers.

IV. EVALUATION

A. Health Care Measurement Results for Blueprint Target Populations

1. Health Care Claims and Clinical Data

Since its inception, a core mission and statutory responsibility of the Blueprint has been to support service delivery reform and evaluate quality and cost outcomes through analysis of multi-payer claims and clinical data. For analysis of multi-payer populations (given the Blueprint's statutory multi-payer responsibilities), the Blueprint partnered with the Green Mountain Care Board (GMCB) to add Blueprint evaluation work to the GMCB's existing all-payer analytics contract. Calendar Year (CY) 2021 is the latest year for which Blueprint has multi-payer, population-level health care measurement data for Vermont. The following annual health care evaluation measures were calculated by Onpoint Health Data, under contract with the GMCB and Blueprint program. Claims-based measurement results are derived from the Vermont Health Care Uniform Reporting and Evaluation System (VHCURES), Vermont's all-payer claims database managed by the GMCB. Clinical/hybrid measures for CY 2019 used records from the Blueprint's recently discontinued Vermont Clinical Registry, and clinical/hybrid measures for CY 2020 and 2021 used clinical data from Vermont Information Technology Leaders (VITL). Blueprint practice and provider registry information used for primary-care patient attribution was derived from the Blueprint's own web portal database. Further details related to the Blueprint CY 2021 community health profile measures are posted on the Blueprint for Health website.

Populations of Analysis

In CY 2021, 65.1% of VHCURES members who received primary care services were served by Blueprint Patient-Centered Medical Homes (PCMHs). Because of the large degree of overlap, measurement results for the total VHCURES population and for the PCMH-attributed population are generally similar. Consistent with prior annual reports, results are presented for the wider primary-care service target population of VHCURES members (i.e., individuals enrolled in a health plan reporting to VHCURES), minus a small number of exceptions. This represents a multi-payer member sample, independent of primary-care attribution and independent of Accountable Care Organization attribution. In 2021, this VHCURES data represented 444,895 people, or 69.0% of Vermont's 2021 population.

As in prior Blueprint annual reports, this report attempts to address the significant shift in the VHCURES data due to the 2016 Gobeille vs. Liberty Mutual Insurance Company U.S. Supreme Court decision. This decision allowed health care plans falling under Employee Retirement Income Security Act of 1974 authority to opt out of submitting data to all-payer claims databases, resulting in many of these plans ceasing to submit data to VHCURES. The remaining population represented in VHCURES tended to be older and sicker resulting

in higher average per member per year costs and utilization rates relative to previous years. To address this change and allow comparability with earlier years the Blueprint removed claims associated with self-insured plans no longer submitting after 2016 from all previous years. Analysis indicated that this step achieved greater consistency in age, payer mix, health status, and gender across all years. Of note, this approach has been explored by other states.

In addition to data from self-insured plans no longer submitting, this analysis excludes data from ages less than one year of age due to frequent challenges in separating their claims from their parents' claims during this period, and from ages 65 and older for whom commercial or Medicaid is the primary payer due to difficulties in identifying total cost of care across multiple payers. VHCURES data also does not include federal employees, members of the military, veterans, and people who are uninsured.

Even with these limitations in the data, the following analyses represent health care outcomes for the majority of Vermont residents.

2. Population Counts and Demographics

Statewide Demographics	CY 2021	CY 2021
U.S. Census Population Estimate for Vermont for 2020: 643,077.	Total VHCURES (Excluding Self-Insured) Members	Blueprint PCMH Primary Care Attributed Members
Population N	444,895	263,179
N Adults 18+		77.10%
N Pediatric 1-17		22.90%
Avg. Age	44.7	43.4
% Female	52.00%	54.00%
% Medicaid	32.00%	33.00%
% Medicare	31.00%	30.00%
% Commercial	37.00%	37.00%
% ACG* Healthy Users	9.00%	9.00%
% ACG* Low Risk	13.00%	14.00%
% ACG* Medium Risk	41.00%	45.00%
% ACG* High Risk	16.00%	17.00%
% ACG* Very High Risk	9.00%	10.00%

*ACG risk scores refer to the Johns Hopkins Adjusted Clinical Group risk stratification methodology. The sum of the ACG risk percentages is less than 100% because not all patients receive an ACG risk score due to a lack of claims.

Evaluation measure results are presented in the appendix of this report. In those results, regional breakouts are based on Vermont Department of Health HSA4 Hospital Service Areas. A map of these Hospital Service Areas can be found on the Vermont Department of Health website.

B. Expenditures and savings for the period

1. Blueprint Expenditures

Blueprint for Health Annual Budget by Program Elements and Funding Source

Blueprint Program Elements	Annualized Budget for 2023	Description	Money Flow	Payer Participation
Patient-Centered Medical Home (PCMH) Payments	$12.257,240	PCMH Per Member Per Month (PMPM) Quality Payments to Practices for NCQA Recognition	From Payers to Practices (Parent Organizations)	All Payers (Includes Medicare)
Community Health Teams (Core/Primary Care)	$10,061,010	Teams support PCMH practice and interface with community services	From Payers to Local Hospital (or FQHC)	All Payers (Includes Medicare)
Spoke Staff (Extended CHT)*	$7,442,438	RN & Counselor teams support MOUD prescribers	From Payer to Local Hospital (or FQHC)	DVHA/Medicaid
PII PMPM Payment to Specialty Practices	$166,778^	Attestation to program elements	From Payer to Practices	DVHA/Medicaid
PII PMPM Payment to PCMH Practices	$87,138^	Attestation to program elements	From Payer to Practices	DVHA/Medicaid
PII One-Time Practice Payments	$2,485	Workflow changes for screening, same-day long-acting reversable contraception	From Payer to Practices	DVHA/Medicaid
PII Social Workers (Extended CHT)	$980,182	Staff for brief interventions and navigation to services	From Payer to Local Hospitals (or FQHC)	DVHA/Medicaid
PII Program Management	$19,250	Program Administration and staff supervision	Grant to PPNNE	DVHA/Medicaid
Program Management	$1,427,000	Change management & program administration	Grant to Local Hospital (or FQHC)	DVHA/Medicaid
Quality Improvement Facilitators	$1,238,044	In-practice QI coaching for NCQA, ACO priorities, and practice priorities	Grant to Local Hospital (or FQHC) or Contract w/QI facilitator	DVHA/Medicaid
Community Self-Management Programs	$664,163	Memorandum of Understanding with Department of Health to support local Self-Management Programs	VDH grants to Local Hospital (or FQHC)	DVHA/Medicaid

Training Contracts/Grant(s)	13,100.00 184,983.00	PII UVM Faculty Trainings Dartmouth Spoke Provider Trainings	Contracts with Vendors	DVHA/Medicaid VDH
Health IT Grant **for staffing to manage Support and Services at Home (SASH) care management system**	$205,000	Grant to administrative entity for the Vermont SASH program, for staffing.	Grant to Senior Housing Organization	DVHA/Medicaid
Data and Analytics Contracts				
All-Payer and Medicaid Analytics	$604,600	Program evaluation for performance payments and for State and Federal reporting	Contract with Vendor	DVHA/Medicaid
Patient Experience of Care Survey	$237,290	Survey of Vermonters served in primary care in accordance with statute	Contract with Vendor	DVHA/Medicaid
Blueprint **Central Office Staff**	$1,058,566	Central office Blueprint program staff	State Employees	DVHA/Medicaid

* Vermont Department of Health manages Hubs
^Fourth quarter data is not yet available for PII PMPM payments, therefore
an estimated fourth quarter dollar amount was used when calculating annual PII PMPM costs.

C. Results of patient and provider satisfaction surveys

The Blueprint for Health (Blueprint) reports annually the patient experience of care as required by Vermont Statute. Since 2011, this task has been fulfilled through the administration of the CAHPS Clinician and Group Survey with Patient-Centered Medical Home (PCMH) questions included. The outcomes for this survey provide the broadest statewide look at patient experience of primary care in Vermont. The number of practices that participated in the 2022 survey was 128, which is an increase from 123 practices in 2021 and an increase from 120 practices in 2020. The number of surveys that were fielded were 57,384 with 10,577 adults and 1,632 pediatric patients responding. The combined response rate was 21.3% which is up from 17.6% in 2021

The results are also used to support PCMH recognition by the National Committee for Quality Assurance (NCQA), and, most recently, as part of the quality reporting under payer contracts with OneCare Vermont under the All-Payer Accountable Care Organization Model.

D. Results of Act 167 Data Extract Analysis

In June of 2023, the Blueprint for Health received an extract of claims data for the fiscal years ending in 2019, 2020, 2021, and 2022. This data was categorized in multiple ways, including a breakdown between patients attributed to Blueprint affiliated PCMH practices and those attributed to other primary care practices. The dataset also included an attribution of individuals to a Mental Health and Substance Use (MH/SUD) category if the individual had at least two outpatient claims or one inpatient claim with specific diagnosis codes. Analysis of this data resulted in several valuable insights regarding the state of health care in Vermont and the effectiveness of the Blueprint's initiatives.

Insights gained into the overall Vermont population included the following:

- The proportion of individuals with MH/SUD claims has been increasing from 25.1% in 2019 to 26.1% in 2022.
- The proportion of emergency department claims with a relevant MH/SUD diagnosis code has not changed in a statistically significant way over the past four years.
- The proportion of individuals with a primary care visit has declined from 71.5% in 2019 to 69.0% in 2022.
- Overall pharmacy costs per person have risen 11.2% after adjustment for inflation since 2019.
- Overall medical costs per person have declined 8.2% after adjustment for inflation since 2019.

In addition, the data analysis provided support for the effectiveness of Blueprint initiatives, including the following:

- Blueprint PCMH practices have a higher proportion of individuals in the MH/SUD category than non-Blueprint practices. The difference is statistically significant at the p=0.01 level and is growing over time.
- There is no statistically significant difference in the overall proportion of individuals with Emergency Department claims between individuals attributed to Blueprint PCMH practices and those attributed to non-Blueprint primary care practices.
- A lower proportion of individuals in the MH/SUD category attributed to Blueprint primary care practices have ED claims than of individuals in the MH/SUD category attributed to non-Blueprint primary care practices. This difference is statistically significant at the p=0.01 level and has been consistent throughout all studied years.

Beyond these utilization measures, individuals attributed to Blueprint PCMH practices showed a lower overall health claims cost, as shown in the table below.

Per Member Per Year Medical and Pharmacy Claims for All Individuals

Year Ending	Blueprint Attributed	Non-Blueprint Attributed	Difference
2019	$8,059.97	$10,435.74	$2,376.17
2020	$7,711.31	$10,298.18	$2,586.86
2021	$8,254.25	$11,005.17	$2,750.91
2022	$8,580.73	$11,253.14	$2,672.41

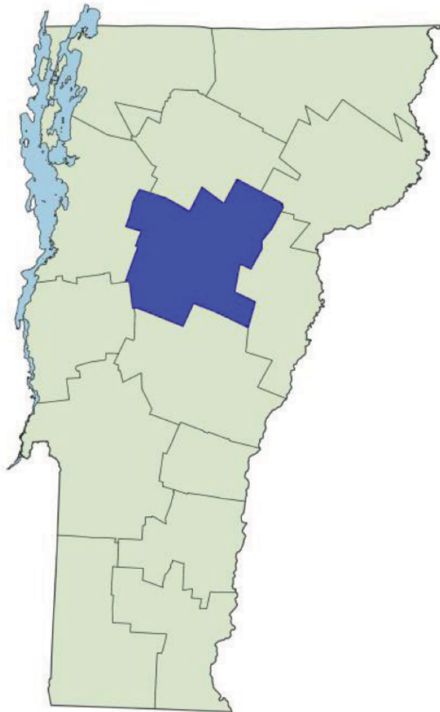
Furthermore, the annualized rate of increase of overall claims is 1.6% for Blueprint PCMH attributed individuals compared to 1.9% for non-Blueprint attributed individuals (not adjusted for inflation).

This analysis provides a recent year update to past work done on the Blueprint's effectiveness at controlling health care costs and providing high quality primary care to Vermonters.

V. HEALTH SERVICE AREAS

The Blueprint staff in each Health Service Area (HSA) are responsible for the continued success of the program and have worked during 2023 to address the ongoing needs of their communities. The following section of the report includes information provided by each HSA.

Blueprint Leadership Gathering
October 2, 2023
at the Waterbury State Office Complex



Barre Health Service Area

Program Manager: Michelle Gilmour

48,839	Heath Service Area Total Population
29,564	Blueprint Practices Patient Attribution
11.3	Community Health Team Staff Full Time Equivalents (FTEs)
4.55	Spoke staff FTEs
0.75	Pregnancy Intention Initiative Staff FTEs
3,477	Community Health Team Patient Count (January-September 2023-may include duplicates)
272	Spoke-Eligible Patient Population (Average August-October 2023, Medicaid only)

Community Health Team

The Barre health service area consists of 10 Blueprint engaged Patient Centered Medical Homes, of which one is also a Federally Qualified Health Center. The Community Health Team (CHT) has continued to evolve throughout Fiscal Year 2023, with multiple staffing models in place. In May we marked 1 year since our CHT social workers and RN care managers were absorbed into the University of Vermont Health Network (UVMHN) Population Health Service Organization (PHSO). As members of this centralized team, they are focused on creating new standardized workflows and documentation templates to capture the patient's goals, additional care team members and the shared care plan. This is occurring at the same time our Central Vermont Medical Center (CVMC) Patient-Centered Medical Homes (PCMH) are working to implement UVMHN High Value Care elements and workflows which include enhanced patient risk stratification, pre-visit planning, standardized scheduling templates and algorithms responsive to the patient level of risk and need for additional support.

> Our practices are better able to provide high quality patient care because of the Blueprint PCMH framework and funding.
>
> **- Administrator in Primary Care**

Community Health Team
CONTINUED

Work continues to define how the care manager role fits into the PCMH care team and workflows, both when physically located on site and when virtually available by phone. Our Quality Improvement (QI) Facilitator, employed by the PHSO, is part of the team developing and supporting our practices through the ongoing PCMH standardization and improvement work. CVMC employs 3 Registered Dietitians & Certified Diabetes Care and Education Specialists as members of our CHT. They provide diabetes education, nutritional counseling and support the patient in making behavioral changes to improve their health in ways that might not otherwise be reimbursed by insurance. In addition to seeing referred patients for 1:1 visits they have begun panel review and management. In one practice they've been able to lower the percentage of patients aged 18-75 with a diagnosis of diabetes mellitus whose most recent hemoglobin A1c was NOT in the last year or was greater than 9.0% from 21% to 13%. We are working to spread this model to our other practices.

Our team engaged in the Pregnancy Intention Initiative has done great work to get the One Key Question data accessible and reportable from within the medical record. In addition, this team is continually looking for ways to engage our higher risk patients sooner to connect them with additional supports, like Washington County Mental Health's Doula program or support through the Family Center of Washington County. We continue to explore how we can improve our coordination for pregnant individuals struggling with substance use to ensure a successful delivery as well as continued connection to care post-partem.

Barre Health Service Area
Continued

Achievements & Accomplishments

The CVMC Medication Assisted Treatment team and our community partners have continued our strong collaboration to address the impact of problematic substance use. Education and distribution of harm reduction supports and resources has been a key strategy with efforts made to expand clean needle distribution sites and increase easy access to harm reduction kits across our community. CVMC placed an emphasis on training primary care and express care staff and we now have 9 sites offering harm reduction kits. In collaboration with our local prevention coalition, Central Vermont Prevention Coalition, distribution of Naloxbox can be found in 8 sites in our community with 11 more pending. Monthly meetings of the Central Vermont Opioid Council with representation from the local Spokes, Hub, Central Vermont Turning Point Recovery Center and CVMC Emergency Department (ED) occur to track, coordinate, and modify services to better meet the needs of those seeking help for opioid treatment. Most recently, CVMC has piloted an initiative called Refocus on Alcohol Dependence, as alcohol is by far the most common drug for which people present to the CVMC ED. Individuals who come to the ED for an alcohol related visit are seen by a recovery coach and the treating healthcare provider, offered the opportunity to initiate medication to help manage cravings while fast tracking a referral to their primary care provider or local substance use specialty care provider to sustain the medication and engage the patient in ongoing treatment. This effort has been warmly received and has offered improved care to patients in need of substance use treatment.

Barre Health Service Area
Continued

Achievements & Accomplishments
CONTINUED

THRIVE is our Accountable Community for Health and was the recipient of a VT Community Health Equity Partnership grant, dedicated to promoting health equity within our community. Community conversations, coffee shop chats, hotel rounds and listening sessions with local agency staff were leveraged to hear directly from those identified as marginalized or underserved in the community about their experiences and needs. Through the health equity project, $25,000 in funding was provided to nine organizations and projects targeting needs of marginalized members in our community.

Future Goals

As we move into the new year the Barre service area will be reviewing our Community Health Improvement Plan and associated strategies to assess our successes and continued areas for improvement. Staffing shortages and recruiting talent is an ongoing challenge, contributed to by shortages in housing and childcare. The historic flooding in July that hit our region has only exacerbated this problem. As we continue to focus on increased screening for mental health and vital conditions that impact health, we should anticipate identification of more need, making it even more important for coordination among and with the resources that exist within the community.

The funding from the Vermont Blueprint for Health has empowered medical providers to engage in collaborative efforts with a diverse array of trained staff members. This includes, but is not limited to, social workers, mental health professionals, alcohol and drug counselors, and registered nurses. As a cohesive team, we've effectively addressed the specific needs of our community, delivering comprehensive care that reinforces the health and well-being of our patients. We wholeheartedly endorse the Blueprint's mission, which focuses on providing evidence-based, patient- and family-centered, cost-effective whole-person care. We eagerly anticipate the Blueprint's expansion, envisioning continued opportunities for growth and development!

– Primary Care NP

Bennington Health Service Area

Program Manager: Todd Salvesvold

28,980	Heath Service Area Total Population
16,810	Blueprint Practices Patient Attribution
6.45	Community Health Team (CHT) Staff Full Time Equivalents (FTEs)
7.2	Spoke staff FTEs
1	Pregnancy Intention Initiative Staff FTEs
3,788	Community Health Team Patient Count (January-September 2023-may include duplicates)
391	Spoke-Eligible Patient Population (Average August-October 2023, Medicaid only)

Community Health Team

In 2023, the Bennington CHT served 14 practice locations across the Health Service Area (HSA). These practices include one Federally Qualified Health Center (FQHC), five hospital owned practices, six independent practices and two specialty care offices (OBGYN and SaVida). Included in this total, Bennington Blueprint for Health supported four Patient Centered Medical Home (PCMH) sites that provided Medication Assisted Treatment (MAT) services in addition to primary care, and two PCMH sites that participated in Pregnancy Intention Initiative (PII). Furthermore, we recently collaborated with our local designated agency (United Counseling Service) to provide MAT services in addition to their standard behavioral health care.

The Bennington CHT also provided the support of a Registered Dietician and Community Health Navigator who followed a centralized support model for the Bennington HSA. These staff identified community members in need of services via a referral system generated by providers, peers and patients themselves. The CHT team members collaborate across agencies and disciplines to ensure effective care coordination of routine and complex care, specifically around care transitions. This is highlighted by the formalization of care planning documentation within the electronic medical records system of Southwestern Vermont Medical Center (SVMC). Care recommendations created by Blueprint staff become an active part of a patient's treatment plan and viewable to all, whereas previous RN documentation was done in a separate section of the EMR and not readily available.

It should be noted that the Bennington HSA did experience some staffing and practice changes in 2023, In July, we saw the closure of Brookside Pediatric and Adolescent Services which had received the services of a 0.2 FTE RN and a 0.1 therapist. In addition, October saw the closure of the primary care offices of Drs. Wood and Hearst who supported the same FTE percentage mentioned above.

Bennington Health Service Area
Continued

Achievements & Accomplishments

The Bennington Spoke Program expanded the number of service locations in Spring of 2023, with the addition of MAT providers at United Counseling Service (UCS). This was a welcomed addition to the community, as UCS provides many comprehensive services under one roof. Patients receiving treatment for an Opioid Use Disorder (OUD) or Alcohol Use Disorder (AUD) at UCS can also access pharmacy, intensive outpatient treatment, individual therapy, as well as peer recovery support all within the same organization. In November of 2023, UCS added a full-time prescriber to their MAT team, expanding the number of patients they can serve. Additionally, the SVMC Emergency Department (ED) continues to offer RAM and RTA services to those who are seeking recovery. In partnership with Turing Point, the Spoke system of Bennington County was able to offer all patients requesting RAM services an appointment with a MAT provider within 72 hours, and in over 75% of cases, on the same day.

Our CHT continues to focus on reducing the number of individuals who may board in acute care settings awaiting long-term care placement due to unmet needs that prevent them from remaining in a community setting. In partnership with SVMC primary care offices, Blueprint RNs have been monitoring their patient panels for those with chronic conditions, frequent ED visits and/or hospitalizations. When it has been identified that a patient meeting these criteria lack power of attorney, advanced directives and/or guardianship, the Blueprint RN reaches out to the patient and family to determine if they can offer education or support on these matters. In addition, Blueprint staff maintains daily contract with the ED to identify any patients served by a Blueprint practice that may be at-risk of placement but lack the necessary documentation to facilitate transfer.

> A Medicare wellness nurse came to me about a patient that she had recently met. She told me that the patient voiced concerns regarding their finances and ability of afford medication. The patient told her that they were approved for benefits but never completed the paperwork. I immediately set up an appointment with the patient. They again stated that the paperwork was overwhelming and did not think they had the ability to complete it. I reached out to an RN Case Manager at VA clinic; they connected me with the VA social worker that helps with benefits. I scheduled a second meeting with everyone above and the paperwork was completed, and the patient is now getting their medications free of charge. In addition, they were assigned a benefits specialist should they have any additional needs in the future. They were very happy to get the help!
>
> **- Blueprint Community Health Team RN**

Our PII program continues to be a highly utilized program within the service area, and recently obtained the services of an RN with extensive experience in the OBGYN and pediatrics worlds. Her expertise has led to the relaunch of some well-needed initiatives in Bennington, including the “diaper bank” and personal hygiene product donation program. She also works very closely with the Community Health Navigator,

Bennington Health Service Area
Continued

Achievements & Accomplishments
CONTINUED

The QI Facilitator in the Bennington Health Service Area focused heavily on the continued relationship development and engagement with each practice. They supported each office with Calendar year 2023 reporting and documentation to ensure continued PCMH status. In addition, they work closely with offices to be sure they are aware of upcoming changes in 2024, specifically in the areas of electronic medical record system alignment and office workflows. Lastly, they are anticipating the PCMH "onboarding" of two newly formed primary care offices, BeWell Primary Care (formally Brookside Pediatrics) and the Primary Care office of Dr. Burdick (formally Drs. Wood and Hearst). Both offices launched in the second half of 2023, with an expected first or second quarter entry into the Blueprint system expected.

Future Goals

In 2023, it was identified that alcohol-use disorder (AUD) was a high area of need in Bennington County. To address this community need, SVMC developed a formal AUD detox inpatient program to support those in need of treatment. While discharge care planning was initially provided to patients in partnership with the Turning Point Center of Bennington (TPC), it has been noted that some patients decline recommendations for follow-up inpatient rehabilitation, thus increasing the likelihood of relapse. To address this issue, Bennington Blueprint, in partnership with SaVida Health, United Counseling Service, SVMC Inpatient Social Work and TPC are developing a workflow whereby those not transitioning to an inpatient setting will receive the support of a comprehensive outpatient team to support their recovery. Through this arrangement, patients eligible for Blueprint services will have access Spoke staff (when outpatient MAT is indicated), CHT services (as many patients with an AUD have co-occurring medial issues) and access to the Blueprint Registered Dietician as necessary. As all Spoke locations in the HSA will be presented as treatment options, patients will have choice in care and peer recovery support as provided by UCS and TPC. Furthermore, this team will be able to visit with the patient at bedside, which will facilitate program registration and decrease the likelihood the patient will be lost to contact after discharge.

Brattleboro Health Service Area

Program Manager: Rebecca Burns

23,684	Heath Service Area Total Population
13,535	Blueprint Practices Patient Attribution
4.7	Community Health Team Staff Full Time Equivalents (FTEs)
2.2	Spoke staff FTEs
0.5	Pregnancy Intention Initiative Staff FTEs
1,732	Community Health Team Patient Count (January-September 2023-may include duplicates)
141	Spoke-Eligible Patient Population (Average August-October 2023, Medicaid only)

Community Health Team

The Brattleboro Health Service Area (HSA) is unique in that is has two hospitals, Brattleboro Memorial Hospital and Grace Cottage Hospital. Within the HSA we have eight Primary Care Practices who are participating in the Patient Centered Medical Home (PCMH) program and are a combination of private practices and hospital owned practices. The Brattleboro Memorial Hospital owned practices are Brattleboro Internal Medicine, Brattleboro Family Medicine, Maplewood Family Practice, Putney Family Health and Windham Family Practice. Grace Cottage has one primary care practice, Grace Cottage Family Health. Brattleboro Primary care is an independent practice with both an Adult Practice and a Pediatric practice.

The Community Health Team (CHT) in the Brattleboro HSA is a hybrid model with some staff in a centralized team and some embedded directly into the practice with pass-through funding. This has allowed practices to prioritize their individual needs with the type of staff they hire to support the practice. Our CHT funds currently support people in the positions of Registered Dieticians, Care Coordinators, Spoke Counselors and Spoke Nurses, Health Coaches and Social Workers.

Achievements & Accomplishments

This year the Blueprint CHT staff have provided free services to over 1,732 community members. These services have been able to assist people in their individual health journey! The services provided by CHT staff are an extension of Primary Care and are crucial for patients to have. A patient said, “You all are so great with the services you provide. You got me in to see the dietician so quickly.” Being able to adjust care to meet the needs of each individual patient is one of the most important benefits of the Community Health Team. This sentiment is also true for the Pregnancy Intention Initiative (PII) and the Spoke program as well.

The Pregnancy Intention Initiative has been able to provide over 1000 SBINS(Screening brief intervention and navigation to services screenings) to patients which resulted in over 400 referrals to the social worker for brief interventions. This service is imperative to the wellbeing of the patients served by this practice.

Brattleboro Health Service Area
Continued

Achievements & Accomplishments
CONTINUED

Spoke services are being supported by Grace Cottage Family Health and Savida in the Brattleboro HSA. Patients can receive their medications for opioid use disorder (MOUD) and receive support through care coordination and counseling.

Key work for the Brattleboro HSA has been to focus on patients having better experiences in our Patient Centered Medical Homes through team-based care with panel management for chronic conditions and care coordination. Our Quality Improvement Facilitator has been working hard assisting practices in attesting for Patient Centered Medical Home certification.

Future Goals

The Brattleboro HSA is looking to train our community on a shared team-based care model in the next year. This work will be done through our Accountable Communities for Health (ACH) group in partnerships with the Agency for Human Services. The Brattleboro HSA also has a goal of embedding more staff into primary care practices to be more involved in the team-based care model.

"You all are so great with the services you provide. You got me in to see the dietician so quickly."

- Patient

"Thank you for your work on my behalf with setting up a therapist. I am sure having you advocate for me was largely helpful in being accepted so quickly."

- PII Patient

"It was so great to have someone that I could talk to and not worry about paying a co-pay or needing to come in. It was so great!"

- Patient

Burlington Health Service Area

Program Manager: Michelle Farnsworth

119,193	Heath Service Area Total Population
86,681	Blueprint Practices Patient Attribution
38.46	Community Health Team Staff Full Time Equivalents (FTEs)
17.5	Spoke staff FTEs
1.2	Pregnancy Intention Initiative Staff FTEs
27,516	Community Health Team Patient Count (January-September 2023-may include duplicates)
858	Spoke-Eligible Patient Population (Average August-October 2023, Medicaid only)

Community Health Team

The Burlington Health Service Area (HSA) Community Health Team (CHT) is deployed across 25 organizations in 36 unique Patient-Centered Medical Home locations to meet the varied and individual needs of our community's participating primary care practices. There are three categories into which our HSA breaks down: (1) our Federally Qualified Health Centers (FQHC) - Community Health Centers; (2) our independently owned primary care practices; and (3) our network of hospital-owned primary care practices.

Many of our CHT members (48%) are hired through our Blueprint Administrative entity and deployed within practices to provide wrap-around services that help our patients address barriers to care and access additional resources to meet their health goals successfully. Other CHT members (52%) are hired directly by a practice that opts to receive pass-through funding so they can embed and deploy staff in a way that best suits their practice needs. In the Burlington HSA, there are 32.9 FTEs employed with CHT funding and 5.5 FTEs employed with CHT Expansion funding (including DULCE staff) so far. CHT roles include care coordinators, social workers, panel managers, health coaches, and registered dietitians. The Burlington Health Service Area includes 12 practices participating in the Pregnancy Intention Initiative (PII) program and 1.2 dedicated social workers. 28 practices provide Spoke services, with 17.5 RNs and Mental Health/Substance Abuse Clinicians dedicated to the program.

> "We have focused on building and nurturing relationships with community therapists to expedite therapy referrals and most appropriately match patients. This has been vital work due to the lack of therapist availability since the onset of COVID-19."
>
> **– Social Worker, Pregnancy Intention Initiative**

Community Health Team
CONTINUED

There are many opportunities within our HSA for formal care coordination amongst teams, which include: quarterly countywide All Spoke Meetings, Care Coordination in Chittenden County Meetings, and various meetings with our Accountable Care Organization (ACO). Most care coordination happens through our staffs' knowledge of community resources and the work of the CHT/Spoke/PII in our greater community, which allows for constant outreach and connection.

What I love most about health coaching is creating a safe, nurturing space for clients to dream. We often get so attached to the 'to dos' and the 'should dos' that we forget to take a step back and think about what our ideal state of health and wellbeing would really be! In most cases, no matter the client's stage of readiness, I start my work with clients by discussing their current state of self-care, often using a satisfaction scale in the lifestyle pillar areas of movement, nutrition, sleep, connectivity, and stress management. Then we make sure to spend time on what their vision of optimal health would be if there were no barriers in their way. Answering the questions: What do you really want? What could be possible for you? All the while, I'm picking up on change talk, reflecting the client's strengths and values, and using other tools in a coach's toolbox such as mindfulness and co-brainstorming when needed. Starting in this dream space builds our rapport and helps lays a solid foundation for sustainable change. Because, after all, it's easier to invest our time and energy on a goal that we truly believe in.

- Blueprint CHT-funded Health Coach

Burlington Health Service Area
Continued

The MOUD teams play a critical role in helping to support patients with substance use disorders. From assisting new mothers in getting diapers to assessing suicidality to providing emotional and logistical care to victims of sex trafficking, our staff work closely with both patients and providers to address a variety of challenges every day. Over the course of years, they have become trusted sources of compassionate and unconditional support by consistently being present, doing what they say they're going to do, and acting in the best interest of their patients.

– Mental Health/Substance Use Clinician, Burlington Spoke Practice

Achievements & Accomplishments

Creating meaningful community connections: Chittenden Accountable Communities for Health (CACH)'s Cultural Humility and Inclusive Health Care Action Team has created "Reflection Fridays" which offers healthcare professionals, social service providers, government staff, and community members the opportunity to come together and talk about important health equity issues. Reflection Fridays help our community develop a shared understanding on topics while creating meaningful connections. Invitations are shared broadly across the community. All are welcome!

The University of Vermont Health Network PHSO Care Management Program received NCQA Accreditation-Case Management (NCQA-CM) in 2023. NCQA-CM is achieved when a program is built on evidence-based practices, quality improvement, standardized documentation, and

Achievements & Accomplishments
CONTINUED

processes. It supports that we, as a program, have met the highest Case Management standards. The program is dedicated to serving patients at the University of Vermont Medical Center, Porter Medical Center, and Central Vermont Medical Center primary care practices.

My Healthy Vermont (MHVT) Self-Management program connects to Vermonters: This year the Burlington HSA has continued to offer virtual programming and attempted to offer in-person and hybrid offerings. We recognize the importance of variety in our workshop offerings to truly meet the needs of Vermonters. We scheduled 15 workshops for Fiscal Year 2023 (FY23) and completed 8 of them; an additional 2 are still running. 159 people from the Burlington HSA participated in My Healthy Vermont workshops in FY23 and we hope to increase participation next year. Our goals for FY24 are to continue to offer virtual and hybrid workshops, with a concerted effort on getting back to in-person as well. We have been establishing relationships within the University of Vermont Medical Center (UVMMC) network as well as with community partners to create meaningful referral pathways. Our goal is to make these connections so it's not "one more thing" for a referring provider to remember but instead a natural next step, that is embedded in the existing workflow, to refer their patients to a My Healthy Vermont program.

PII social workers provide care coordination and assist patients with accessing Long-Acting Reversible Contraception (LARC): The best way to illustrate the great work that Blueprint PII social workers do is by sharing an example. This year, our PII social worker supported a New American patient's family in securing permanent housing as well as year-long childcare financial support and childcare transportation.

Burlington Health Service Area
Continued

This entailed extensive care coordination with Childcare Resource, the City of Burlington's Early Learning Initiative, housing case managers, and pediatric colleagues. This social worker helped this same patient to schedule and access her contraception care (initially Depo shots and later Nexplanon).

Motivational Interviewing and Helping Patient who Hoard Trainings Offered: There were several trainings offered to all Blueprint CHT-funded staff in the Burlington HSA, including Motivational Interviewing and Helping Patients who Hoard. We look forward to more opportunities to offer educational offerings to our Blueprint staff in the year ahead.

> "It is due to the Blueprint that I am able to easily connect with those in my field and know that there isn't competition between us. We instead compete for retention in care, knowing that as long as patients remain in care somewhere, that is all that matters. It's nice to share a common goal directed by a third party. Thanks to the Blueprint I have a pathway to aid my most vulnerable patients and I am so thankful for that."
>
> **- RN, Burlington Spoke Practice**

Identifying trends: The Blueprint QI Facilitators representing the 3 HSAs supporting the UVM Health Network (Burlington, Middlebury, and Barre) have been working to identify Quality Improvement initiatives for collaboration and standardization. The aim is to improve the overall patient experience by identifying trends and implementing solutions.

Achievements & Accomplishments
CONTINUED

Collaboration: The Blueprint QI Facilitators representing the 3 HSAs supporting the UVM Health Network (Burlington, Middlebury, and Barre) collaborated to complete chart reviews for each practice as required for the Blueprint Expansion pilot. Collaboration offers benefits like resource pooling, leveraging each facilitator's unique skills, and creating an efficient quality assurance process.

Supporting Patient Centered Medical Homes (PCMHs) to meet National Committee on Quality Assurance (NCQA) standards effectively: Building on the foundation of quality and patient-centered care, Blueprint Quality Improvement (QI) Facilitators helped practices plan for reporting PCMH standardized measures in 2024, which will allow practices to demonstrate the outcomes of their medical home transformation. In addition, QI Facilitators for the UVM Health Network practices have joined forces to standardize NCQA criteria across the health network to improve care quality, consistency, accreditation, patient experiences, efficiency, and support data-driven decisions. With Blueprint QI Facilitator support all UVM Medical Center and independently-owned PCMHs maintained NCQA PCMH Recognition despite struggling with unprecedented staffing shortages and turnover.

Supporting Practices to implement the Blueprint CHT Expansion Pilot: Blueprint QI facilitators in the Burlington HSA helped practices identify Community Health Team needs as they expand mental health, substance use services, and address health related social needs facing their patient populations.

Burlington Health Service Area
Continued

It's lonely living with chronic pain, even when you are in a room surrounded by loved ones, no one really gets what you're living with, day after day. One of our recent CPSMP graduates noted, with tears and gratitude in his eyes, that this chronic pain workshop helped him to feel less alone. Connection, it's one of the most helpful tools in our toolbox.

– Regional Coordinator, Self-Management

Future Goals

Care Team participation and shared care planning

- Burlington HSA Blueprint Team will continue to develop a solid understanding of the new OneCare Vermont Population Health Model to support practices as they integrate this model into the Patient Center Medical Home (PCMH).
- Care Coordination in Chittenden County Meetings take place monthly and are attended by a diverse group of community members. Topics covered include: care plans, screening requirements, UVMMC's Working to Reduce Admissions to the ED Program, and more.

Providing and improving Care Management Services

- UVMMC launched a care management program in July, 2022. In the first year of operation, the program served 2,615 patients. Innovation and excellence in Care Management (CM) is proactively identifying patients at higher risk for medical and/or social complexities and who might benefit

Middlebury Health Service Area

Program Manager: Emmy Wollenburg

19,999	Heath Service Area Total Population
16,407	Blueprint Practices Patient Attribution
7.82	Community Health Team Staff Full Time Equivalents (FTEs)
2.77	Spoke staff FTEs
.75	Pregnancy Intention Initiative Staff FTEs
3213	Community Health Team Patient Count (January-September 2023-may include duplicates)
191	Spoke-Eligible Patient Population (Average August-October 2023, Medicaid only)

I have so much gratitude for the Blueprint for Health's Hub and Spoke Care Model and the dedication to creating and maintaining the community connections necessary for the person-centered care required for those in our community suffering from Substance Use Disorder. The Provider, RN and Counselor team is situated to support the whole person, thoroughly address the Social Determinants of Health (SDOH) and focus on the behavioral change aspects of the recovery process. The external partnerships and connections we have been able to create and foster over the past year further the breadth of our abilities to meet our patients where they are at and remove the many barriers to recovery.

- RN, Middlebury Spoke Practice

Community Health Team

The Middlebury Health Service Area's (HSA) Community Health Team (CHT) is deployed across 9 Patient-Centered Medical Homes (PCMH) to meet the varied and individual needs of our community's participating primary care practices. There are two categories into which our HSA breaks down: (1) our independently owned primary care practices and (2) our network of hospital-owned primary care practices, and (3) our FQHC - Mountain Community Health.

Many of our CHT members (70%) are hired through our Blueprint Administrative entity and deployed within practices to provide wrap-around services that help our patients address barriers to care and access additional resources to meet their health goals successfully. Other CHT members (30%) are hired directly by a practice that opts to receive pass-through funding so they can embed and deploy staff in a way that best suits their practice needs. In the Middlebury HSA, there are 6.0 FTEs employed with CHT funding, and 1.8 FTEs employed with CHT Expansion funding so far. CHT roles are mostly care coordinators, social workers, and registered dietitians. The Middlebury Health Service Area includes 1 practice participating in the Pregnancy Intention Initiative (PII) program and a 0.75 dedicated social worker. 4 practices provide MOUD/Spoke services, with 2.8 RNs and Mental Health/Substance Abuse Clinicians dedicated to the program.

Community Health Team
CONTINUED

There are many opportunities within our HSA for formal care coordination amongst teams, which include: monthly Addison County Community Health Action Team (CHAT) Meetings that includes representation from a diverse group of local community partners, including: CSAC, Addison County Parent Child Center, Project Independence, Building Bright Futures, United Way of Addison County, WomenSafe, AgeWell, Porter Medical Center, several primary care practices, and others. Work continues to better understand data sharing opportunities between Blueprint and OneCare Vermont.

The Middlebury Health Service Area welcomed both a new Blueprint Program Manager and a new Blueprint Quality Improvement (QI) Facilitator this year.

Achievements & Accomplishments

Accountable Communities for Health impacting marginalized populations: During the past year, the Addison County Community Health Action Team (CHAT) formed a Steering Committee to support the Vermont Community Health Equity Partnership (VTCHEP) Grant through the Vermont Public Health Institute (VTPHI) and helped complete assessments, review applications, and provide guidance. The projects that received VTCHEP funding presented their projects to the larger group to increase knowledge and awareness around Diversity, Equity, and Inclusion in our community. Projects focused on marginalized populations including LGBTQIA+, BIPOC, older Vermonters, and teens with a focus on Physical and Mental Wellbeing. CHAT's Data Meeting in May was a real highlight. It was the first time since 2019 that community partners around the region came together to share and review data relevant to the region and to talk about opportunities for collaboration to address different challenges and needs of the community.

Middlebury Health Service Area
Continued

Standardizing quality work across the UVM Health Network: The 3 QI facilitators supporting the UVM Health Network's 22 Patient-Centered Medical Homes joined forces to enhance patient care by pooling resources and leveraging each facilitator's unique skills. These facilitators collaborated to identify Quality Improvement initiatives within each service area, focus on standardization, and optimize workflows for PCMH staff. Projects ranged from closing care gaps to supporting the Blueprint Expansion Pilot to their dedicated effort to standardize National Committee on Quality Assurance (NCQA) requirements across the health network. The NCQA standardization work is already improving care quality, consistency, ease of accreditation, patient experience, efficiency, and data-driven decisions. They established PCMH-specific reporting dashboards, an internal SharePoint site for staff data sharing, and a direct communication channel for UVMHN staff to connect with their assigned Blueprint QI Facilitator.

PII social worker provides necessary support to patients: The Blueprint social worker in the PII program provides thorough biopsychosocial assessments that include evaluating mental health, safety, and social determinants of health. She offers short-term counseling and works collaboratively with internal and external colleagues to create multi-disciplinary teams of support for patients.

> Patients are continually surprised and elated that they have access to free mental health support through our office. Patients create strong relationships with providers in our office and are able to circle back for support of providers and counselor as needed, not just for GYN/OB care.
>
> **– Social Worker, Pregnancy Intention Initiative**

Morrisville Health Service Area

Program Manager: Hannah Ancel

20,252	Heath Service Area Total Population
17,184	Blueprint Practices Patient Attribution
12.65	Community Health Team Staff Full Time Equivalents (FTEs)
5.1	Spoke staff FTEs
0.5	Pregnancy Intention Initiative Staff FTEs
2,566	Community Health Team Patient Count (January-September 2023-may include duplicates)
268	Spoke-Eligible Patient Population (Average August-October 2023, Medicaid only)

Community Health Team

Thanks to the unique capitated funding model of the Blueprint for Health, we are fortunate to have 17 Community Health Team (CHT) members across the Morrisville Health Service Area. Our CHT works in primary care, the emergency department, and Women's Center to support patients and their practitioners in removing barriers to their health. This includes housing, mental health care, transportation, insurance, food, employment, and general navigation of the health care system. These are all factors that primary care providers cannot solve alone in a 15-minute visit, thus providing an essential component of team-based care that many providers are looking for when choosing to enter or stay in primary care.

> I am so grateful for CHT. I can't imagine working without these wonderful people and services. It is a vital program that keeps our community healthy.
>
> **- Nurse Practitioner**

The team also visits community sites such as the seasonal shelter, hotels, and community meals to engage those who do not have regular primary care, insurance, and may have other barriers to care such as transportation. On several occasions our nurses have identified significant medical needs for which care was immediately coordinated.

Our care coordination includes outreach to patients after they have been to the hospital to coordinate their follow up. As a result, we see almost no patients continuing to have high emergency department utilization (3 or more visits in a 3-month period) from one quarter to the next. The success of this work is measured by our health service area ranking first in the state for the Accountable Care Organization (ACO) measure pertaining to reducing ED re-visits.

During the July flooding, several towns (Cambridge, Johnson, Wolcott, and Hardwick) in the Lamoille area were severely impacted. Our regional Community Health Team was able to reach community

Community Health Team
CONTINUED

members impacted in their neighborhoods, at the temporary shelters, at community meal sites and when they came in to see a provider. The CHT worked to ensure those impacted knew how to seek primary care given the risks of infection and respiratory challenges due to the flood water, exposure to mold and other hazards. The team connected residents to a variety of resources to meet their immediate needs. Thanks to our partnership with Meals on Wheels we were able to offer prepared meals as needed. The damage from the flood has had an impact on both physical and mental health for residents. This complexity has required ongoing care coordination by the CHT in several cases. The lack of housing in our community, which was severely exacerbated by the flooding, has left many facing unhealthy living conditions or homelessness. Our team continues to work closely with community partners, town leaders and other representatives to coordinate the response and advocate for the resources still needed.

> "I was recently at a community meeting where someone asked, 'how do those who are homeless get health care?' A community partner quickly responded, 'the Community Health Team is out in the community every week connecting with people, assessing their health needs, helping them get insurance and scheduling appointments.' The fact that a community partner could speak so quickly to the presence and impact of the CHT shows how much CHT is part of the fabric of the community."
>
> **– Blueprint Program Manager**

Morrisville Health Service Area
Continued

Achievements & Accomplishments

Thanks to a Health Resources and Services Administration (HRSA) grant in partnership with Bi-State Primary Care Association, we have been able to resolve some food access challenges by using Instacart for grocery delivery to patients who are food insecure and at risk for cardiovascular disease. We are hopeful that if sustained funding is available, we can grow the program to address food insecurity that is impacting the health and well-being of so many of our patients.

The Lamoille Medication Assisted Treatment (MAT) Team is currently working with 9 spoke sites across the HSA, which includes more than 25 prescribers. We serve 375 plus patients throughout the year, two-thirds of which are Medicaid patients. We have seen some changes in patient panels since Medicaid annual redetermination has resumed, and many of our patients are no longer Medicaid eligible. In the last year we have also seen a growing interest in Sublocade or other long-acting Buprenorphine injections. We have also seen some patients be successful in tapering off Buprenorphine. To get upstream with prescribing practices, Spoke Program Manager, Meagan DeWitt, worked with practitioners to develop education and workflows for managing chronic pain and opioid prescribing within the primary care setting.

Morrisville Health Service Area

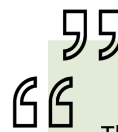
Continued

Achievements & Accomplishments

CONTINUED

In October Lamoille Health Partners merged with Family Practice Associates in Cambridge. We have started working with them develop a system of care for Medication for Opiate Use Disorder to provide greater access to treatment in this remote region.

In collaboration with the Blueprint expansion, we are excited to hire a full-time clinician to support expanding treatment to include alcohol use disorder. Spoke Program Manager, Meagan DeWitt has been working with practitioners on increasing access to detox support for patients with alcohol use disorder. This included the development of a screening tool and workflow based on the recommended level of care.



The Community Health Team is like a quality glue: When the health care system is fractured and fragmented, CHT comes in to fill and connect the gaps in care resulting in improved health outcomes.

RN CHT Care Coordinator

Future Goals

The Lamoille Health Collaborative has selected Findhelp as a platform for making closed-loop referrals between health and human service organizations in the region. After completing a needs and readiness assessment in 2022, it was determined such a tool would be valuable in addressing inequities in access to services and increasing overall coordination and continuity of care. With support from the Vermont Food Bank, over this coming year of implementation we will evaluate in effectiveness of improving patient & client experience, improved health outcomes, and utilization of the right services at the right time.

By focusing our expanded CHT positions on mental health brief intervention, we are aiming to increase access to immediate supports. This will open appointments for one to six sessions of targeted support, free to patients. If patients need support beyond these targeted sessions, the CHT Care Coordinator will be able to connect them to a therapist for longer term counseling. This increased access to immediate support, paired with consistent screening for depression, suicidal risk, and substance use, will enhance our ability to prevent suicide and overdose related deaths and get people the care they need more quickly with a comprehensive team.

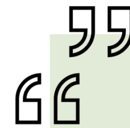
Newport Health Service Area

Program Manager: Mandy Chapman

21,594	Heath Service Area Total Population
15,662	Blueprint Practices Patient Attribution
7.4	Community Health Team Staff Full Time Equivalents (FTEs)
2.95	Spoke staff FTEs
1	Pregnancy Intention Initiative Staff FTEs
1607	Community Health Team Patient Count (January-September 2023-may include duplicates)
143	Spoke-Eligible Patient Population (Average August-October 2023, Medicaid only)

Community Health Team

The Community Health Team (CHT) provides quality, coordinated care to patients within the Newport Health Service Area (HSA). The team consists of RN and clinical care coordinators, social workers, dieticians, and community health workers who are embedded in the Rural Health Clinics in Newport and Barton as well as the Federally Qualified Health Center (FQHC) primary care practice in Island Pond. One care coordinator spends half of her time working as a care coordinator for North Country Pediatrics and the other half of her time as the Pregnancy Intention Initiative (PII) coordinator at North Country OBGYN. Both the pediatric practice and the specialty practice fall under the same Leadership and often the care coordinator will follow patients who have recently given birth and babies from the OBGYN office to the pediatric office which ensures a unique level of continuity of care. The CHT embedded within the North Country Hospital and Health System practices share the same leadership as the inpatient case managers which enables the two teams to work seamlessly and collaboratively together, ensuring coordination of care throughout the ambulatory setting as well as care transitions from inpatient to outpatient. The CHT meets monthly with partner organizations to share resources and identify areas for further collaboration across the region. The Newport HSA recently established a second monthly meeting to convene with partner agencies to address system level gaps and barriers to care by identifying collaborative solutions.



> We can expand upon the care and guidance provided at the patient visit to ensure patients are able to follow through and achieve their best possible health outcomes. Patients I work with tell me all the time how grateful they are for my support as they want to achieve better health but often its overwhelming and they don't know where to start.
>
> **– Newport Care Coordinator**

Newport Health Service Area
Continued

Achievements & Accomplishments

A major focus for the Blueprint team in the Newport HSA this past year was aligning required quality improvement metrics in our Accountable Care Organization (ACO) and Patient Centered Medical Home (PCMH) work to leverage more resources and focus on population health efforts that will impact the largest portion of our patients in the greatest way. One example is the work done to ensure that our diabetic patient population is receiving consistent care meeting evidence-based practice standards. Through this project we increased the number of diabetic patients receiving two A1Cs per year, increased self-management education offerings and outreach, and increased the number of referrals to both our RN chronic care coordinators and dieticians. A success story that epitomizes the impact this aligned effort had on our population comes from our chronic care nurse who states, "I have been working with a complex diabetic patient whose A1C in July was at 12.2%. Just three months after enrolling in care coordination his A1C has dropped to 7.9%! He hasn't had an A1C that low in years!! He also completed his diabetic eye exam and meets with me monthly now. He likes that I will keep him accountable. Our next goal is to progress to an A1C below 7%."

The Newport team dedicated significant time this year to systematically improving the care coordination process as well as mapping out key workflows. The team achieved this through engagement of the community heath team staff in identifying workflow deficiencies and knowledge gaps as well as electronic medical record challenges. Once identified, the team worked to develop written protocols, provided education and trainings, new text macros for more efficient documentation and began to outline a care coordination handbook. We end this year working on developing care coordination graduation criteria, standardizing our intake process, and implementing a more robust social determinants of health screening.

This year we established a PII taskforce consisting of the QI facilitator, the CHT lead (who previously worked as the PII resource coordinator), the Clinical Performance Specialist, the current PII resource coordinator, the Practice Manager, and the Director of Specialty practices. This team met periodically throughout the year to review PII deliverables and identify data metrics to track performance on initiative deliverables. Another responsibility of this team was to determine quality of care gaps in current workflows.

The Newport Health Service Area Medication Assisted Treatment (MAT) program operates through BAART and the spoke sites, Island Pond Health Center and SaVida. Currently, MAT services are not offered within the remaining primary care practices. There are approximately 140 patients receiving MAT services in our health service area. Historically, the MAT pass through funding has been managed by the St. Johnsbury program manager. The Newport program manager worked closely with NCH leadership, Northern Counties leadership and the SaVida program manager to assume passthrough responsibility of the MAT funding for the Newport HSA. This has resulted in strengthening the relationship between the MAT hub and spoke sites with North Country hospital and MAT presentations in the primary care settings on services provided this year.

Newport Health Service Area
Continued

Future Goals

The Blueprint team in Newport has continued to improve upon and seek out new opportunities to strengthen cross collaboration within our region. One example of this is an award secured for a grant funded public health initiative that will span both the Newport and St. Johnsbury health service areas. Participation in this initiative will provide both regions with training on a public health regenerative leadership style which is founded on strong cross collaboration and a community collective approach. The Manager of Population Health and the CHT Supervisor meet regularly with the regional field director of the Agency of Human Services to explore current system level gaps in care transitions in our region and are identifying ways to work more effectively together. This relationship building and development of avenues for cross collaboration is a means to reducing duplication of services as well as create smoother transitions of care for the patients.

"My inspiration for this work and the Community Health team model is renewed each time I hear a success story of a complex and difficult patient who is successfully engaged by a community health team member and empowered as well as given the tools to take charge of their own health. We would not be able to provide the high-quality patient centered care that we do without them."

-Newport Program Manager

"In the HSA with the highest measurable levels social determinants of health it has been invaluable to have the resources of the CHT to meet patients' needs. Having practiced before the implementation of Blueprint support and at times of full or less than full staffing of the CHT, patients are served now in ways that were not possible without that resource. We can provide resource lists but the ability to meet the patient where they are at and guide them to the community supports creates a true care collaboration. For example, many patients are illiterate, and a list does no good, mental health challenges limit their ability to call or ask on their own, many just don't know where to look. In a different vein the space to provide health coaching has made a major difference in the measured outcomes for chronic disease management. Diabetics who are reached out to prospectively on a regular basis consistently improve their glucose control. Often you can see them backslide as there is more need and not enough funding for ongoing wraparound support. I and all my fellow physicians use this resource daily to the betterment of our patients and allowing increased and improved access and outcomes."

–North Country Primary Care Physician

Randolph Health Service Area

Program Manager: Katja Evans

10,655	Heath Service Area Total Population
10,257	Blueprint Practices Patient Attribution
5.25	Community Health Team Staff Full Time Equivalents (FTEs)
1.2	Spoke staff FTEs
0.5	Pregnancy Intention Initiative Staff FTEs
530	Community Health Team Patient Count (January-September 2023-may include duplicates)
85	Spoke-Eligible Patient Population (Average August-October 2023, Medicaid only)

Community Health Team

In the Randolph Health Service Area (HSA) we have Community Health Team (CHT) staff members embedded in six out of seven locations. CHT staff members are part of our HSA primary care practices, including all Gifford Health Care Patient Centered Medical Home (PCMH) locations and South Royalton Health Center, an independent pediatric practice. At Gifford, the CHT is made up of clinical and non-clinical roles, including RN Care Managers and Care Coordinators. Additionally, Gifford CHT has two certified Health Coaches and a Tobacco Treatment Specialist as part of the team.

Other members of the Gifford Blueprint team include a Spoke Nurse and a Licensed Clinical Social Worker who support the Addiction Medicine and Obstetrics and Midwifery practices, respectively.

As the administrative entity, Gifford provides pass-through funding to South Royalton Health Center for their Care Manager and Care Coordinator and to Clara Martin Center for their Spoke RNs.

Members of the CHT regularly meet with area community partners as well as clinical providers to facilitate care coordination and support positive patient outcomes.

> Our embedded Community Health Team member is extremely helpful with patients who are in the clinic. We all know it's important to catch folks in the moment when they are willing so having the Community Health Team right there, ready to step in, taking the time to assist, is invaluable.
>
> **– Gifford Primary Care Practice Manager**

Randolph Health Service Area

Continued

Achievements & Accomplishments

This year we embedded CHT members into our largest primary care practice. Previously, due to space constraints, our team had been on the same campus but separate from the practice. We now have dedicated space within the practice, allowing our team to be readily available for patients and providers every weekday. We have had positive feedback from providers and clinical staff members on the benefit of this embedded team. The CHTs are able to collaborate with other members of the patient care team and meet with patients during or after appointments as needed. The ability to provide outreach in the moment, when patients are in the practice, is an invaluable aspect to the embedded model.

In May, our HSA welcomed a Quality Improvement Facilitator to the team. This long-vacant position feels like the missing piece for the future facing work we are embarking on with our CHT. This role will help support and engage clinics in Quality Improvement projects as well as within our own CHT.

In October, Gifford Health Care transitioned to a new Electronic Medical Records (EMR) system. The organization had previously been working in four EMRs which were all brought under one system - Meditech. Our CHT has been working to optimize workflows around documentation, scheduling, and patient registries. This work allows us to maximize outreach and monitor populations of focus based on our screening tools.

Our Pregnancy Intention Initiative social worker worked with the Vermont Department of Health to bring monthly WIC clinics to the Obstetrics and Midwifery Practice. These clinics provide the opportunity of early engagement with WIC to establish supports around families.

Having our Community Health Team member able to meet with patients at their primary care appointment is such a valuable asset. They are able to provide support and guide patients to needed community services in a timely manner and, as a provider, I appreciate the value of having this resource right in our clinic.

– Gifford Primary Care Provider

Future Goals

Our main priority is implementing the Blueprint Expansion across our PCMH practices. South Royalton Health Center hired on an expanded position in October 2023. We hope to have these roles filled in our PCMH practices with a focus on clinical staffing to support patients around mental health and substance use needs.

The Randolph HSA Program Manager and Quality Improvement Facilitator are working collaboratively with the Gifford Population Health Department to optimize the new EMR. This includes collaboration around Registries and Patient Panels. Our goal is to source data from the EMR that will facilitate strategic planning around populations of focus and maximize the capacity of our Community Health Team.

In 2024, we plan to relaunch our Community Collaborative with a focus on referral processes across community partners.

Rutland Health Service Area

Program Manager: Merideth Drude

45,260	Heath Service Area Total Population
31,484	Blueprint Practices Patient Attribution
10.14	Community Health Team Staff Full Time Equivalents (FTEs)
7.44	Spoke staff FTEs
1.0	Pregnancy Intention Initiative Staff FTEs
3,618	Community Health Team Patient Count (January-September 2023-may include duplicates)
383	Spoke-Eligible Patient Population (Average August-October 2023, Medicaid only)

Community Health Team

The Community Health Team (CHT) in the Rutland Health Service Area (HSA) utilizes several approaches to meet the needs of our patients, practices, and community at large. The Core CHT members are Rutland Regional Medical Center employees, utilizing roles of RN, Social Work/Behavioral Health Care Coordinators, and Community Health Worker. The Core CHT assists in meeting Care Coordination needs for both Adult and Pediatric populations. The Adult Core CHT supports patients in a variety of settings including the hospital, home, practice and community settings. The Pediatric Core CHT Team spends the majority of their time in the practice setting to support a higher success of engagement during both sick and well visits. The Community Health Worker position supports the use of home visiting as well as meeting the needs of Social Determinants of Health (SDOH) screenings. CHT funding also supports embedded Care Management Positions within Community Health Centers, the Federally Qualified Health Centers (FQHCs) of the Rutland HSA.

This funding assists Community Health Centers employed Care Managers in supporting Chronic Conditions Management for established patients. Panel Management funds are also utilized to assist Independent Practices (Associates in Primary Care, Drs. Peter and Lisa Hogenkamp, and Marble Valley Health Works) to support access to care for established patients, with a primary focus on preventative care.

A strength of the Blueprint is to offer the flexibility to meet the needs of the practices and community at large and the staffing model of the Rutland CHT reflects this. Utilizing a variety of staffing roles and models assists in supporting a Patient Centered approach to address the complexity of needs and Care Coordination efforts of all patients. The varying types of practices within the Rutland HSA (a FQHC with 6 practice sites, a sole Nurse Practitioner practice, an independent family practice and a concierge practice) utilize the CHT and its funding to align and maximize Care Coordination effectiveness.

Community Health Team
CONTINUED

Another area of focus is regarding Emergency Department (ED) Utilization and access to Primary Care. The Community Health Team utilizes a Care Coordination position to provide direct outreach to patients who present to the Rutland Regional Medical Center (RRMC) Emergency Department with identified SDOH needs and lack a Primary Care provider. This position allows for the time to support the navigation and access to community services that prevent access to Primary Care and provide a warm hand off to the accepting practice. This position also provides patient education on accessing care at the right time and right place, supports the establishment and engagement of care teams, and facilitates care conferences.

The Pregnancy Intention Initiative (PII) is also active in the Rutland HSA, supporting the Rutland Women's Healthcare practice. Greater than 3900 SDOH screenings were completed by the Rutland Women's Healthcare, with 48% of patients scoring a positive indication for a SDOH need. While the ultimate goal for this initiative is to support intended pregnancy and reduce unintended pregnancy, the ability to address SDOH needs has fostered collaboration amongst health care and community service organizations to improve communication and access to services.

> "The Vermont Blueprint for Health provides an invaluable resource and support for Community Health as a Spoke provider. Together with our partnership, patients are able to receive access to enhanced services, staff are trained with the latest substance use disorder treatment methods and our agency has the support needed to hire the right team to provide care."
>
> **- Director of Behavioral Health and MAT Services**

Rutland Health Service Area
Continued

The impact of CHT funds in support of the Spoke practices within the Rutland Health Service Area is far reaching. There are close to 400 active Spoke patients being served within the Rutland HSA. There is strong engagement and workflows that exists between the RRMC Emergency Department, West Ridge (Rutland's HUB), the 4 designated Spoke practices, and our robust Peer Recovery Coaches through Turning Point. All designed Spoke funding is passed through to support the hiring of Registered Nurses and Drug and Alcohol Counselors.

Achievements & Accomplishments

The efforts to reduce non-emergent ED Utilization is one that takes a Care Coordination village. While employing a designated Care Coordinator to support this effort, the work rests on the shoulders of many. The ability to communicate with ED providers, established Primary Care Providers and Care Managers, Case Managers through the Designated Agency of Rutland Mental Health, and other social service organizations are all essential in supporting meeting the needs and reducing barriers to access these services. In a sample of 13 patients that have been identified and outreach by the ED Care Coordinator, there has been a decrease in ED Utilization for 11 out of 13 patients, with 8 of those patients decreasing their ED presentations by over 50%.

Another area of success this past year was the hiring of a Pediatric RN Case Manager. This position supports not only the ED Utilization of Pediatric patients, but enhances the access of care coordination services for Pediatric patients with medical

Rutland Health Service Area
Continued

Achievements & Accomplishments
CONTINUED

complexity along with psycho-social needs and supports. Utilizing the skill set of an RN to support Pediatric Care Coordination now mirrors the Adult Core CHT team and strengthens Complex Care Coordination. With the addition of this role, the Community Health Team was also highly engaged and supportive of adding a Pediatric Speech and Language Pathologist (SLP) service line to the RRMC Outpatient Rehab Program, which began in September. The lack of access to Pediatric SLPs in the Rutland HSA to assist with Early Intervention services was an identified community gap and the CHT Pediatric Care Coordination team was actively engaged supporting the creation of this service line. More than 25 children ranging in ages 0-3 have been evaluated in the first few months and are receiving at minimum weekly Speech Language Pathology services.

"The Community Health Team has been an invaluable resource for me as a pediatrician at Community Health Clinics Rutland. They are a professional team with great insight into the resources in the community and a large heart for the children and families in Rutland county where we serve. I truly can not imagine practicing pediatrics without their assistance -it would be a lot like endeavoring on a bicycle journey without air in the tires. Thankfully our organization includes not just air pressure but the highest quality persons in the Community Health Team and I am so appreciative of their tenacious and attentive expertise.

- MD Provider (Pediatrician at Community Health Pediatrics)

Future Goals

As for the rest of the state, a strong focus for the upcoming year will be the implementation of the Blueprint Expansion Pilot program. There are 6 Community Health Centers practice sites and Drs. Peter and Lisa Hogenkamp that are slated to engage in this pilot project. In addition to the opportunity to enhance the access to SDOH screenings, this pilot also offers the ability to better align efforts throughout the Rutland Health Service area to build additional resources with more data information sharing and greater capacity to address not only SDOH needs but the gaps in meeting the demand for these services.

As always, continued evaluation of CHT interventions through data sharing and quality improvement efforts are a constant goal. The ability to enhance screening by building additional staffing structure allows for the ability to maximize on the skill set of each profession receiving CHT funding and lead to more effective and efficient workflow processes to improve access to care while decreasing cost and provide patient centered care coordination services.

Springfield Health Service Area

Program Manager: Tom Dougherty

21,068	Heath Service Area Total Population
10,892	Blueprint Practices Patient Attribution
8.7	Community Health Team Staff Full Time Equivalents (FTEs)
3.5	Spoke staff FTEs
0	Pregnancy Intention Initiative Staff FTEs
1,276	Community Health Team Patient Count (January-September 2023-may include duplicates)
155	Spoke-Eligible Patient Population (Average August-October 2023, Medicaid only)

Community Health Team

Our Community Health Team (CHT), as defined by those staff supported in some part by Blueprint CHT funds, is comprised of a community health worker who serves all practices but also is meant to be available for outreach including making home visits, meeting individuals at other service site or housing programs, etc.; a registered dietician, a diabetes care and education specialists; CHT Lead who is a Psych/FM/DM NP, Spoke Nurses, Medication Assisted Treatment (MAT) counselors and staff dedicated to quality improvement and panel management. This team supports all practices in our area either from a central location or by dedicated time at each location, and collaborates closely with our local critical access hospital, Springfield Hospital, our local Designated Agency-HCRS, and a broad range of community partners. The CHT is a core supplement and support for our clinical care coordinators who are embedded in each primary care practice, the MAT programs, and school-based clinics. Care coordinators assist patients in addressing barriers to care and support individuals' priorities related to their health and wellness and serve as an essential link to navigate and secure services in the community and across the healthcare system.

> Since starting here, I cannot say enough about our CHT team. Their support, enthusiasm and care for patients is unmatched. They go above and beyond for each patient and treat them as if they are the ONLY patient. Their advice and knowledge is one of a kind.
>
> **- Primary Care Provider**

Springfield Health Service Area

Continued

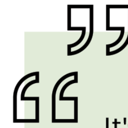
Achievements & Accomplishments

Our CHT was challenged by several staff transitions in 2023 as long-serving team members either retired or moved to new roles. While recruiting replacements, our team demonstrated their flexibility and stretched to continue being responsive to patients and community members, providing assistance with essential services including transportation, health access, food resources, referrals for housing, economic assistance and care management programs.

We supplemented our team with a new mobile-services Community Health Worker (CHW) position supported by a Vermont Department of Health grant, enabling us to reach individuals beyond our clinic facilities. This was put to good use in assisting individuals receiving emergency housing services and those impacted by the severe flooding in July which closed two of our clinics in Ludlow. Team members were very active in the CHW Alliance and the development of the Southern Vermont Area Health Education Center CHW core competency training and in the planning for implementation of the CHT Expansion Pilot. All primary care practices in our HSA have attested for the Expansion and are recruiting for these long-needed positions.

On the Quality Improvement (QI) front, the CHT, working closely with our QI Practice Facilitator, was again essential in enabling all primary care practices in the HSA to be recognized as Patient-Centered Medical Homes (PCMHs). As part of the PCMH work, CHT-supported QI teams recorded improvements in depression screening and follow-up plans, increasing the number of individuals with diabetes-in-control, and maintain high screening rates for breast and colorectal cancer, childhood vaccinations and well child visits.

CHT's central role the provision of care and promoting health and wellness, in particular to those facing economic barriers is evident in these statements from primary care providers across our service area.



It's been wonderful working with the Community Health Team. They bring so much experience supporting patients with mental health issues to the table. Providing care for patients with complex social needs is challenging and with them supporting us I feel like I can do my job more effectively.

- Psychiatric Nurse Practitioner

Future Goals

We are very excited about moving forward with the implementation of the CHT Expansion in 2024 and the opportunity this will provide to assist individuals more rapidly and efficiently with behavioral health, and substance use issues and a range of needs related to social determinants of health. New CHWs will be deployed to follow up on an enhanced screening program and be positioned to provide further assessment, brief interventions, and timely referrals to care when appropriate. We expect this program to enable better utilization of our primary care and behavioral health clinicians and in the process improve access. These added CHT resources will also facilitate more focused and effective utilization of our clinical care coordinators who will be more available to assist our complex patients. The Expansion is occurring at an ideal time for our primary practices which are participating in a system-wide initiative to enhance our integrated-care team model which is intended to improve the experience of both patients and providers and the health of our community.

Springfield Health Service Area

Continued

"Working with our one certified diabetes nurse educator feels like we have a whole team of diabetes nurse educators. They are incredibly hard-working, compassionate, and always go the extra mile for patients. They have been incredibly helpful with all aspects of diabetes education, but especially with teaching patients, family members, clinical staff and even providers about continuous glucose monitoring. With their support and guidance, we have been able to utilize this amazing tool for our diabetic patients. I have had many patients improve their glycemic control with continuous glucose monitoring, with or without medication changes. They have been able to spread their knowledge to all of us so we may offer this to more patients. Additionally, we have been able to better preserve access to endocrinologists for those who truly need that level of care. Thank you!"

- Primary Care Provider

"As a Federally Qualified Health Center I believe that the community health care team is the essence of our mission. CHT has provided support for my patients and for me as a provider with good advice helping solve many problems or finding where I can get solutions for my patients. I think the quality of what we do is immeasurably enhanced by the hard work of this group of professionals. I cannot say enough about the wonderful work they do."

- Primary Care Provider

St. Albans Health Service Area

Program Manager: Denise Smith

30,849	Heath Service Area Total Population
20,356	Blueprint Practices Patient Attribution
12.67	Community Health Team Staff Full Time Equivalents (FTEs)
11.64	Spoke staff FTEs
0	Pregnancy Intention Initiative Staff FTEs
4,150	Community Health Team Patient Count (January-September 2023-may include duplicates)
581	Spoke-Eligible Patient Population (Average August-October 2023, Medicaid only)

Community Health Team

The St. Albans Health Service Area (HSA) has a dedicated, compassionate Community Health Team (CHT) who works together across organizations to solve complex and often difficult health challenges affecting rural Vermonters. The core belief of the St. Albans CHT is that we are serving our neighbors, our friends, and our family members in achieving their health goals. Our core CHT team is embedded in each of the 12 Patient Centered Medical Homes (PCMH) in our region and is made up primarily of RN Care Coordinators with Community Health Workers and Behavioral Health Clinicians. We partner with our Regional Behavioral Health Designated Agency, Northwestern Counseling and Support Services to provide the expertise and supervision needed for our integrated behavioral health model. We also employ embedded RN Care Coordinators and Licensed Alcohol and Drug Counselors for our Hub and Spoke Program in each of our Primary Care Offices and specialty clinics, including the Howard Center, SaVida, and BAART.

This program has increased access to the Medication Assisted Treatment (MAT) program in our region immensely for our Opioid Use Disorder (OUD) patients. Currently, our PCMH clinics consist of 2 Pediatric clinics, 2 Primary Care clinics, and 8 clinics that are part of the NOTCH, the region's Federally Qualified Health Center (FQHC). The CHT Team works collaboratively together through our shared goals of supporting our friends, neighbors, and family members in our community. We have a monthly meeting with the core CHT team members, the MAT team, as well as the other care agencies in our region, including home health agencies, long-term care, Age Well, and SASH.

> "While doing the chart reviews for the Blueprint Expansion this fall, I was so impressed with the care planning documentation that the RN Care Coordinators entered. They are so committed to providing exceptional care to their patients."
>
> **- Blueprint QI Facilitator**

St. Albans Health Service Area
Continued

Achievements & Accomplishments

In 2023, our work included:

- Supporting Northwest Counseling and support Services and Cold Hollow Family practice in their Quality Improvement (QI) around Suicide screening.
- Hosting a one-day retreat for CHT to develop appropriate meeting schedules, goal setting, and collaborative work together.
- Working with multiple community partners on addressing youth health issues, leading to great collaboration among schools and NCSS and youth prevention efforts.
- Supporting QI for our annual CAHPS surveys
- Working with multiple partners on reducing hospital readmissions, supporting systems changes to improve transitions of care, and engaging in an inter-agency palliative care collaboration.
- Working to implement the expansion of the Blueprint in our region to provide more support to patients with health-related social needs (HRSN), mental health, and substance use disorder.
- Continuing leadership and facilitation of the CAIRES Accountable Communities for Health to improve collaboration among agencies to support the health needs of our community.

> “Having a mental health counselor at the pediatric office is incredible. With everything going on in the world right now, especially the challenges our children face, has been a lot. It is reassuring to know that if my child needs help, we can access it without having to pay for it. The cost of everything is so expensive these days. This service has saved my child’s life.”
>
> **- Local Mother**

- Supporting migrant health needs by partnering with Bridges to Health, Northwestern Medical Center (NMC), NOTCH, and Monarch Maples to understand barriers and opportunities to providing more consistent and preventative care.
- Facilitating transitions with staffing, leadership, and programmatic changes in our MAT practices.
- Addressing housing needs in our community by partnering on the Homeless Health Equity Grant and identifying a new opportunity to provide Medical Respite Beds to patients discharging from NMC.
- Supporting the work to increase offerings of MyHealthyVT and working with the Franklin-Grand Isle Tobacco Prevention Coalition on prevention efforts throughout the two counties.
- Working with the Abenaki Nation of Missisquoi to improve health outcomes related to chronic diseases.

> “The work the Blueprint Community Health Team does for our community members often goes unnoticed. Very few people realize the care this team takes of our most vulnerable community members. They leave no stone unturned to ensure their patients get what they need to heal. I am in awe of their commitment, dedication, and ability to work in our current resource deprived conditions.”
>
> **- Blueprint Program Manager**

When a patient comes into NMC and I ask them about their primary care, 9 times out of 10 they know the name of their RN Care Coordinator at their Primary Care Practice. Those ladies do a great job supporting their patients and helping them get the resources they need.

- NMC Care Manager

Future Goals

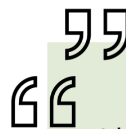
During our summer retreat, the CHT identified goals they would like to address collaboratively. We are currently in the process of creating a logic model based on the goals that they identified. Below are the 4 goals that were outlined by the team.

1. Improve our CHT's collaboration, communication, educational, and personal development opportunities this year. The Blueprint Team will develop meeting agendas that reflect shared learning and outcome requests, provide educational and personal development opportunities, and explore collaborative resources to improve group communications and care coordination. This will result in a more efficient and productive team that is able to address the needs of our friends, neighbors, and family members.
2. Convene leaders in our region to develop a 5 to 10-year plan that will improve access to equitable long-term, elderly, memory care, to our friends, neighbors, and family members. By the end of FY24 The Community Health Team and The Blueprint will engage the CAIRES Accountable Communities for Health (ACH) to identify funding, draft a request for proposal, and identify a consultant to develop a Strengths, Weaknesses, Opportunities, and Threats (SWOT) analysis and feasibility

St. Albans Health Service Area

Continued

plan for our region. This will create a roadmap for us to follow to ensure we are providing the right level of care and resources to our community now and in the future.
3. Identify dedicated teams to focus on standards of care in our region related to Social Determinants of Health (SDOH) screening, referral, and care coordination, and chronic disease management, including CHF, COPD, and Diabetes. The teams will work together to establish current state, review national best standard practice, and collaborate to develop regional best practice standards for at least one of the above referenced diseases.
4. Work together to improve access to mental health and substance use disorder by creating collaborative agreements that allow shared assessments for our two designated agencies and other partners to work closer together and minimize duplicative questionnaires for patients to create ease of access, reduce triggering conversations, and support our population struggling with SUD.



I know that I can always count on my embedded behavioral health team to support the mental health challenges of the kiddos in my practice. We love being able to refer someone into this free and accessible service. It is life changing for many children and families to know that they have the support of a qualified mental health provider right at their primary care practice.

- Provider

St. Johnsbury Health Service Area

Program Manager: Diana Gibbs

20,390	Heath Service Area Total Population
14,939	Blueprint Practices Patient Attribution
15.45	Community Health Team Staff Full Time Equivalents (FTEs)
2.98	Spoke staff FTEs
0.75	Pregnancy Intention Initiative Staff FTEs
8618	Community Health Team Patient Count (January-September 2023-may include duplicates)
98	Spoke-Eligible Patient Population (Average August-October 2023, Medicaid only)

Community Health Team

The St. Johnsbury Health Service Area (HSA) Community Health Team (CHT) is essential to providing quality, coordinated care to patients. Our core CHT team staff are embedded within the six local primary care practices, including three Federally Qualified Health Centers (FQHC) operated by Northern Counties Health Care (NCHC) and three Rural Health Clinics operated by Northeastern Vermont Regional Hospital (NVRH). Our CHT includes five Behavioral Health Specialists (BHS), including a BHS Supervisor, and six RN Care Coordinators. For the Pregnancy Intention Initiative, NVRH's Women's Wellness Center practice has an embedded Social Worker. Additional CHT staff include six Community Health Workers (CHWs), including a CHW Lead, who are also embedded in the primary care practices and also can be accessed at NVRH's Community Connections. Community Connections, now in its 21st year, offers trained CHWs who support individuals to find and connect to primary care and social and community services on a walk-in basis.

The CHT meets monthly to learn about new or existing resources and services, to network, and to share resources with partner agencies throughout the region. The St. Johnsbury HSA holds two other monthly meetings- Integrated Care Team and Core Team- during which partner agencies throughout the region attend and discuss the Team Based Care approach and examine system-level gaps and barriers in order to identify collaborative solutions to reduce or remove barriers to care. In a mindful effort to leverage the knowledge and experiences of frontline staff, we've created parallel workflows between the two team meetings to ensure transparency and collective impact for systems-level challenges to enhance patient experience and outcomes. The long-standing commitment to collaboration and Team Based Care by all health and human service partners in our HSA is paramount to the continued success experienced with implementation of Blueprint and ACO healthcare reform efforts.

Achievements & Accomplishments

Starting in 2017, the St. Johnsbury HSA has developed a robust three-part Team Based Care (TBC) training curriculum to include a basic level for CHT and other frontline staff, as well as basics for leadership to influence a culture of TBC in our HSA and creating buy-in from the top down. These trainings are offered to new staff at any healthcare or community partner agency in our region, and we will continue to hold these trainings to strengthen Team Based Care in our community. In 2023, we trained 25 leaders in the leadership level, totaling 41 since initiation in 2021, and 12 in the basic level with another training in December, totaling a potential of 190 trained since 2017. Serving as a resource for TBC education, our staff have trained CHT members in a neighboring HSA, employees from all over the state, Vermont Chronic Care Initiative (VCCI) staff, AHS Field Directors, and the short-term hotel workers (co-facilitating with the VCCI Senior RN Case Manager).

In the last year, we've prioritized creating alignment between the Accountable Care Organization (ACO), National Committee on Quality Assurance (NCQA) recognition, and Blueprint for Health, leading to shared goals and objectives for all quality/payer initiatives within the HSA. This alignment has created efficiencies, transparency, and valuable collaboration resulting in improved workflows, processes, and most importantly, enhanced patient outcomes. Quality Improvement Facilitation work has focused extensively on workflow modification to ensure data is captured for standard measure reporting. Additionally, regional data dashboards have been developed and refined for Pregnancy Intention Initiative (PII), standard quality measures, screening, and ACO Population Health Measures and attribution to inform quality improvement opportunities and other efforts utilizing for real-time information. The newly developed PII dashboard has been discussed by the Women's Health Task Force at NVRH for quite some time.

St. Johnsbury Health Service Area

Continued

This dashboard offers visibility to total patients seen, number of Long-Acting Reversible Contraception (LARC) insertions, number of behavioral health visits, number of screenings performed and entered into the EMR including the one key question and food, housing, and financial insecurity. Allowing for ease of follow-up tracking, the dashboard also shares the number of referrals due to a positive screen. This resource offers significant value for workflow and process improvement for the practice.

To support Hub and Spoke providers, we have integrated St. Johnsbury and Newport HSAs in our Regional Medication Assisted Treatment (MAT) Meeting to support greater collaboration across our region for patients receiving care for SUD. Practices have transitioned from Spoke services being provided by BAART to having staff within the practice provide Spoke services to their patients. The Northeast Kingdom Regional MAT Meeting has been an exceptional platform for Spokes and Hubs to share knowledge and expertise. All primary care practices within the HSA that see patients 18+ are Spokes.

"The presence of our CHTs is essential to the success of our practice and our patients. We recently had a period of time when both positions were vacant and the lack of support clearly had a negative impact on our patients and staff. The CHT assist greatly in improving outcomes, and ensuring patients are accessing the right care/support in the right place at the right time! They are easily available to provide timely support and intervention for our patients and staff. I hope that they continue to be supported by the Blueprint."

- Practice Operations Director

St. Johnsbury Health Service Area
Continued

Achievements & Accomplishments
CONTINUED

To support implementation of the Blueprint Expansion Pilot, we created presentations and held informational meetings to educate practices and other stakeholders to prepare them for attestation and integration of expansion CHT staffing. Through collaboration among the Program Manager and QI Facilitator, practices had been engaged to discuss staffing and workflows in order to inform expansion CHT needs. To support the FQHC as their practices span three HSAs, we worked with Morrisville and Newport Program Managers to streamline expansion conversations and to develop monthly reporting tools. This approach has been advantageous for administrative entities and the practice leadership.

Future Goals

Moving forward, we will continue to be well-aligned across all quality and payer initiatives to achieve goals related to chronic disease management and reducing deaths by overdose/suicide. Prevention is our aim with access to care, sooner, as a means to achieve this goal. Our approach to prevention includes continually building and evolving our relationships and networking with social care community partners. In 2023 we focused on expanding TBC work across community partners, including neighboring HSAs, to continue to reinforce the culture, to maintain and refine our regional approach, and to ensure working knowledge of the key concepts of the model. We will continue to expand this work throughout other segments of our social care partners, including developing an orientation for new staff for TBC and providing an understanding of local resources to effectively address chronic disease and suicide prevention.

Northern Counties Health Care has Chronic Care Coordinators and Community Health Workers on their Community Health Teams. Over the last year we have seen some turnover and have done a lot of education on care plans and care management. We have discussed how their positions make such a huge difference in patients' and family lives such as helping to receive medications they need, assisting with transportation, looking at the social determinants of health and supporting patients with these, educating on new diagnosis and chronic conditions, care managing on complex patients to support keeping them out of the ER and hospital. Our staff meet patients and families where they are at, they may meet with them once or continuously over the year. Our teams are part of the community meetings and work together for the patients' needs. We meet as a team on a monthly basis, are very fortunate to have a Health Service Area Practice Facilitator and a NVRH Innovations Coordinator who does a lot of work with the ACO, be part of our meetings so we can all learn and grow together. There has been great conversations from these meetings as we learn and grow together. We are very fortunate to work in such a supportive service area.

- Clinical Nurse Educator and Compliance Specialist

St. Johnsbury Health Service Area

Continued

Future Goals

CONTINUED

We have applied for the Suicide Prevention Mini-Grant again for 2024. This work will include a collaboration with NVRH's adult primary care practices and our designated agency partners. Our goal is to heighten and hone the communication between providers, their patients and our designated agency community partners via use of efficient and effective documentation that is visible to all care team members. This data could inform additional opportunities to prevent and intervene earlier.

We will continue to support our practices with implementing the Blueprint CHT Expansion Pilot, including identifying staffing, developing and refining workflows, and ensuring screening and intervention occurs for our patients. We will also continue to refine administrative processes to streamline and create transparency between practices and the administrative entity.

I have seen excellent diabetes outcomes since involving the care coordinator. Patients are very appreciative of additional attention and support provided in-house. ... CHT staff are hugely important to be able to connect in real time about urgent issues, provide warm hand-offs, access phone and chart notes easily.

– Nurse Practitioner

I cannot even imagine how I would practice without this team! The Care Coordinator calls patients in between visits to check on glucose control, medication compliance, helps with the most complicated patients with the most barriers to care to help bridge those barriers. The CHW helps to find resources for our patients. The Behavioral Health Specialist supports those patients who cannot care for themselves due to their mental health. CHT staff are invaluable to allow me more time to concentrate on the medical concerns and provides huge benefit to the patients; they are completely necessary for us to provide comprehensive Medical Home quality care.

– MD Provider

Windsor Health Service Area

Program Manager: Melanie Sheehan

31,628	Heath Service Area Total Population
12,200	Blueprint Practices Patient Attribution
10.43	Community Health Team Staff Full Time Equivalents (FTEs)
3.0	Spoke staff FTEs
0	Pregnancy Intention Initiative Staff FTEs
1,779	Community Health Team Patient Count (January-September 2023-may include duplicates)
300	Spoke-Eligible Patient Population (Average August-October 2023, Medicaid only)

Community Health Team

There are two community health teams (CHTs) in the Windsor Health Service area (HSA), one for the Mt. Ascutney region and the other for the Northern Region covered by Little Rivers Healthcare (LRHC), in Bradford. The Mt. Ascutney (MAHHC) team, embedded in Primary Care within the Hospital, meets weekly for care coordination and team-based care across several organizations including but not limited to: SASH, Aging in Place Nurses, Visiting Nurses, Hospice, Area Agencies on Aging, Medication Assisted Treatment (MAT) practices, VT Free & Referral Clinics, Vermont Chronic Care Initiative, Volunteers in Action, Family Wellness Programs, Designated Mental Health Agency, Economic Services, Domestic Violence, and Economic Development partners.

The Upper Valley/LRHC team, embedded in various clinical practices spread across the area, meets monthly together with Clara Martin. These monthly meetings are less about care coordination because this team is adept at reaching out and collaborating in their day-to-day activities.

However, when we meet monthly, they stay connected to us as the administrative entity and we troubleshoot challenging areas. Most recently, that has been related to housing and food security. Most recently, we have connected this team to the VT Foodbank about setting up a Veggie Van Go or similar Foodbank program in that region.

Each team meets with community partners on a regular basis (MAHHC meets weekly, and other teams meet monthly) to collaborate, jointly problem-solve and share resources. Each team addresses clinical care, social and emotional care, behavioral health, and Social Determinants of Health.

Windsor Health Service Area

Continued

General Information

Little Rivers Health Care

The Upper Valley Unified Community Collaborative continues to meet monthly to discuss community health needs and initiatives. In 2023, work continued pertaining to the focus areas of: transportation, food access, and integrating resources. They also refined and will soon launch their 2024 Community Health Needs Assessment, which was enhanced by getting input from multiple partners who participate in the collaborative.

MAT – LRHC continues to maintain an average of 34 MAT clients per month. Their staffing has remained consistent with a part-time RN and Counselor.

PII – LRHC is a PII participating provider, assisted with help from Windsor HSA's Quality Improvement Facilitator.

I consider our community health team as one of the most important members of our practice. Their dedicated work has helped so many complex patients with various social needs and challenges. It has definitely improved the quality of care for our patients and saved countless hours of time for busy primary care providers.
A few of many examples of such is the patient education about the purpose of the prescribed medications, counseling on diabetes and hypertension, visiting the patients at their homes to review their home situations, helping to obtain important medications, and assisting with various social needs through the social worker.

-Provider

Upper Valley Pediatrics

A full-time LPN provides care coordination for the practice. Upper Valley Pediatrics has experienced significant staffing turnover in the last year. As a result, their voice has been noticeably absent during monthly CHT meetings, however the team assures us that they hear from the practice where there are needs to be met for clients or troubleshooting needed. UVP has a strong relationship with our Blueprint QI facilitator and are working towards the NCQA recertification at the end of this year.

White River Family Practice

Continues collaboration with Clara Martin Center by having a Mental Health Therapist/Counselor, meet with patients to facilitate them getting mental health services initiated the CCM program utilizing Dr. Drake's consulting to assist with patients with mental health concerns. This service was enhanced by adding another day of Lisa’s services to the practice through the BP Expansion pilot.

PII – White River Family Practice also joined the Pregnancy Intention Initiative this past year and is also supported in this by the BP QI facilitator.

MAT – Sadly, one of the MAT practices serving the White River Junction Area, Bradford Psychiatric Associates, closed their practice. However, the clients were successfully absorbed into CT Valley Addiction recovery Spoke practice.

General Information
CONTINUED

Mt. Ascutney Hospital and Health Center

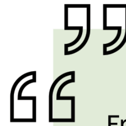
Accomplishments this past year include the successful navigation of major changes in Community Health Department as well as Organizational Leadership. At the HSA level, we are doing more to integrate the Blueprint and Accountable Care Organization work at Community Collaborative meetings by sharing data to drive population health strategies, increase engagement in MyHealthyVT, and increase the utilization of shared care plans across the agencies in the HSA. We have also established a new system of resource sharing across CHT partners and the Community Collaborative through a Google Drive. This is an open access platform so that multiple partners can add and remove resources as they time out.

We have also worked to establish a pilot transportation service with Southeast VT Transit. The project was launched in Windsor VT only in September of 2022 and within the first year, we were able to expand ridership service for persons in neighboring towns of Ascutney and Hartland.

Despite critical shortages in staffing since April at our Primary Care Practices and CHT, we are working with 57% more CHT patients. This is a result of using population health data and outcome metrics to increase outreach. We are seeing improvements in decreasing emergency department revisits, improved diabetes management, and hypertension management.

Lastly, it is worth noting that we have increased shower and laundry utilization at the Windsor Resource Center in order to support the increase in the unhoused population in the area. We have also established a satellite food pantry and diaper bank at the Center.

Windsor Health Service Area
Continued



From participation in the CHT Team meetings, I see firsthand the impact that the CHT Team makes for patients who otherwise would not have the help they need. We discuss our most difficult care management cases and hear all the hard work the CHT team does to ensure that our patients have the best possible outcomes when they are in need.

One astounding story is regarding a homeless gentleman who went missing. The system had failed him and discharged him from 2 hospitals, with a disposition of “home”. Through several phone calls and working connections, one of our CHT team members found him when no one else could. After being found, the CHT team member connected him to VA services, as he was a Veteran. The VA took on the task of connecting him to safe housing. This is the impact our CHT Team can make for anyone that they work with.

- Practice Manager

MAT – In 2023, we were successful in supporting CT Valley Addiction Recovery (CVAR) in hiring their own Spoke staff and they have been working with full Spoke team (1 full-time RN, and 2 part-time counselors) for several months. As previously stated, CVAR absorbed the patient panel from the closing of Bradford Psychiatric Associates.

Having staff directly hired into the practice (rather than hired by MAHHC and placed there) has improved integration and better case management for the clients. Spoke staff, however, join the Blueprint Case Management meetings on a monthly basis at a minimum.

Windsor Health Service Area

Continued

Future Goals

The needs of the people in our communities have shifted dramatically in the last several months, particularly related to housing. We also need to continue to significantly address mental health and substance use disorder. Our future goals are to:

- Maximize utilization of Blueprint Pilot Expansion Resources to address Mental Health and Substance Use Disorder across the HSA
- Engage at least 40 patients attributed to our health system in using our Alcohol Use and Substance Use disorder MAT pathways (now established in our Emergency Department and Inpatient Units)
- Transition to the utilization of OneCare's Arcadia data platform for better population health outcome management and patient outreach while avoiding duplication of services
- Continue to work with Blueprint for Health leadership to clarify Health Service Area boundaries that are strategic and effective, maximizing impact

Planned Parenthood of Northern New England (PPNNE)

Program Manager: Rey Francois

2.80	Pregnancy Intention Initiative Staff FTEs
2,770	Attributed Patients Statewide
807	Patient Encounters- 11 months

Community Health Team

The experience I had was exactly what I needed. It's hard to ask for help in a lot of situations and when it's offered in a life-changing experience it makes all the difference. I didn't have to do the work myself, I just had to say yes to help. I would not have come out stronger without the support I received but actually fear for who I may have become if I declined. I'm forever grateful for the help I have received, and I believe everyone needs this kind of support system during the really hard times.

- Patient

Leadership Changes and New Appointments:

In April, we bid farewell to our previous Program Director of Integrated Behavioral Health, who resigned to pursue other opportunities. We are deeply grateful for her contributions and wish her the best in their future endeavors. We are thrilled that Rey Francois has been appointed the new Program Manager. Rey brings a wealth of experience and a fresh perspective to this role, and we are confident in her ability to lead us forward effectively.

Additionally, we are pleased to announce that Micah O'Connor has been appointed the Lead Integrated Behavioral Health Clinician (IBHC) due to his exceptional dedication to clinical excellence. Micah's extensive knowledge and expertise in this field are well known, and we are confident that his leadership will significantly enhance our clinical services. We look forward to witnessing the positive impact of his leadership and expertise on our team and organization.

As we endeavor to enhance the quality of our services, we seek competent and committed individuals to join our team at our Rutland, St. Johnsbury, and Burlington health centers. This presents an exceptional opportunity for those who seek to make a meaningful impact in healthcare and be part of a dynamic and supportive team.

We are particularly interested in individuals enthusiastic about becoming part of our health centers and contributing to our mission of delivering exceptional services. Our new team members will play a critical role in our journey toward achieving excellence and innovation in patient care. It is worth noting that our health centers in Battleboro, White River Junction, Barre, and Williston are fully staffed.

Community Health Team
CONTINUED

Our Commitment to Quality Healthcare:

Amidst these transitions, our commitment to providing exceptional healthcare services remains steadfast. These changes will strengthen our team and enhance our ability to meet the evolving needs of our community.

We are confident that with the support and dedication of our entire staff and the fresh insights from our new team members, PPNNE (Planned Parenthood of Northern New England) will continue to excel and make a positive difference in the lives of those we serve.

Planned Parenthood has saved another woman's life—mine! They caught my cervical cancer just in time before it fully spread. I knew something was off in my body. I listened to my intuition, and I booked an appointment with Planned Parenthood of Northern New England. Although getting my cancer diagnosis was scary, Planned Parenthood made me feel safe, well cared for, fully seen and heard, and respected. Not only did they get me referral care quickly for my hysterectomy, but their staff also provided me with counseling—everything from my mental health and how I felt about my surgery to the practicalities of helping me find childcare, transportation, and food as I recovered. This is what amazing, inclusive, TOTAL reproductive health care looks like! My loving heart, thankful soul, and my donations go to PPNNE! They save lives every day with preventive care. Planned Parenthood is proactive and is for living life—my life!

- Patient

Planned Parenthood of Northern New England (PPNNE)
Continued

Achievements and Accomplishments

The PPNNE community continues to grapple with the impact of the COVID-19 pandemic and the recent decision to overturn Roe v. Wade. In light of these challenging circumstances, the significance of integrated behavioral health services cannot be understated. As such, the Community Health team staff who we call Patient Support counselors continue to provide invaluable assistance to patients in need while partnering with community organizations to ensure that the community's needs are met.

Despite the ongoing challenges posed by the pandemic, the counselors remain steadfast in their commitment to providing low barrier high-quality support to those who require it most. Their efforts have been instrumental in helping individuals navigate a range of complex issues, including mental health concerns, addiction, and other behavioral health issues.

Going forward, the services provided by the Patient Support counselors will be more critical than ever before. As such, we are grateful for their unwavering dedication and commitment to the community, and we look forward to continuing to work with them to promote the health and well-being of all who call PPNNE home.

A few of the achievements at the community level including presenting at The Pride Center's LGBTQ Health Summit, leading a presentation regarding PSC services at the Brattleboro Health Center, -connecting with many individuals who work to provide resources to the Brattleboro community; such as Groundworks and Health Care and Rehabilitation services.

The Planned Parenthood Support Counselors are also currently working with Dartmouth Hitchcock

Achievements & Accomplishments
CONTINUED

Medical Center's transgender team to advocate for improve accessing to gender affirming surgery for transgender Vermonters. The Support Counselors have also been working to fill the gaps in our Rutland and St. Johnsbury health centers by collaborating with our public affairs team in connecting with community partners in those regions such as the Rutland Free Clinic, Vermont Cares and Northern Counties Health Care.

Our Patient Support Counselors (PSC) have also worked to meet the mental health needs of our patients in the medical setting. After noticing a trend of patients expressing distress and trauma related response during pelvic exams or IUD insertions, our PSCs led a training with our medical staff on how to support patients in recognizing trauma response during exams and how to support the use of basic grounding skills to reduce patient distress during exams. Here our PSCs are not only reducing barriers to care by proving resources to patients and creating connections in the community, but also supporting our ongoing goal of improving trauma informed care and making reproductive healthcare more accessible to all.

Planned Parenthood of Northern New England (PPNNE)
Continued

Future Goals

The goal of this initiative is to employ both formal and informal Continuous Quality Improvement (CQI) practices to steer our work in the Integrated Behavioral Health (IBHSW) program at Planned Parenthood of Northern New England (PPNNE). We have established informal procedures to evaluate our work, which includes regular meetings with the PSCs across the state, a meeting with the PSCs, and a representative from the healthcare delivery team. Our ultimate goal is to enhance and strengthen our relationships with community partners and organizations across the state.

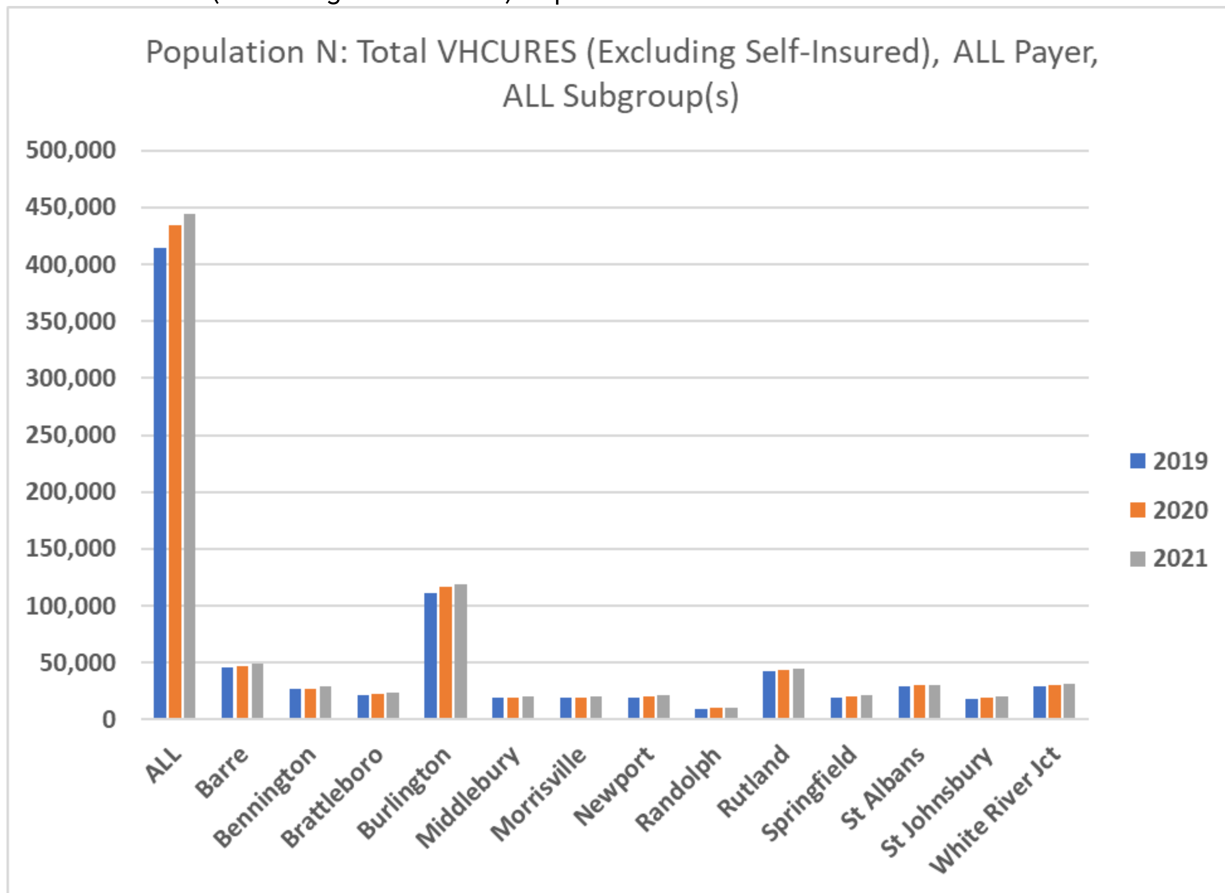
However, one of the challenges we have encountered is the absence of ongoing mental health care. The designated agencies across the state are understaffed, and waiting lists are lengthy. We have addressed this challenge by providing bridge services, which are short-term support services until patients can receive long-term care in the community. Although not all patients opt for this service, it is offered to enhance the continuity of care, especially for patients who need immediate support such as non-crisis level suicidal ideation, recent life stressors, or need for distress tolerance skills. Visits occur based on patient need, ranging from weekly to monthly up to approximately 6 sessions. We do not provide long term trauma treatment, but we are committed to providing high-quality, short-term care services and resource coordination to our patients.

VI. APPENDIX: EVALUATION MEASURE RESULTS

The following charts display various health care quality measures reported in the Vermont Health Care Uniform Reporting and Evaluation System (VHCURES), Vermont's all payer claims database. These measures are provided as an overview of health utilization trends in Vermont.

Population N (Person Counts) By HSA:

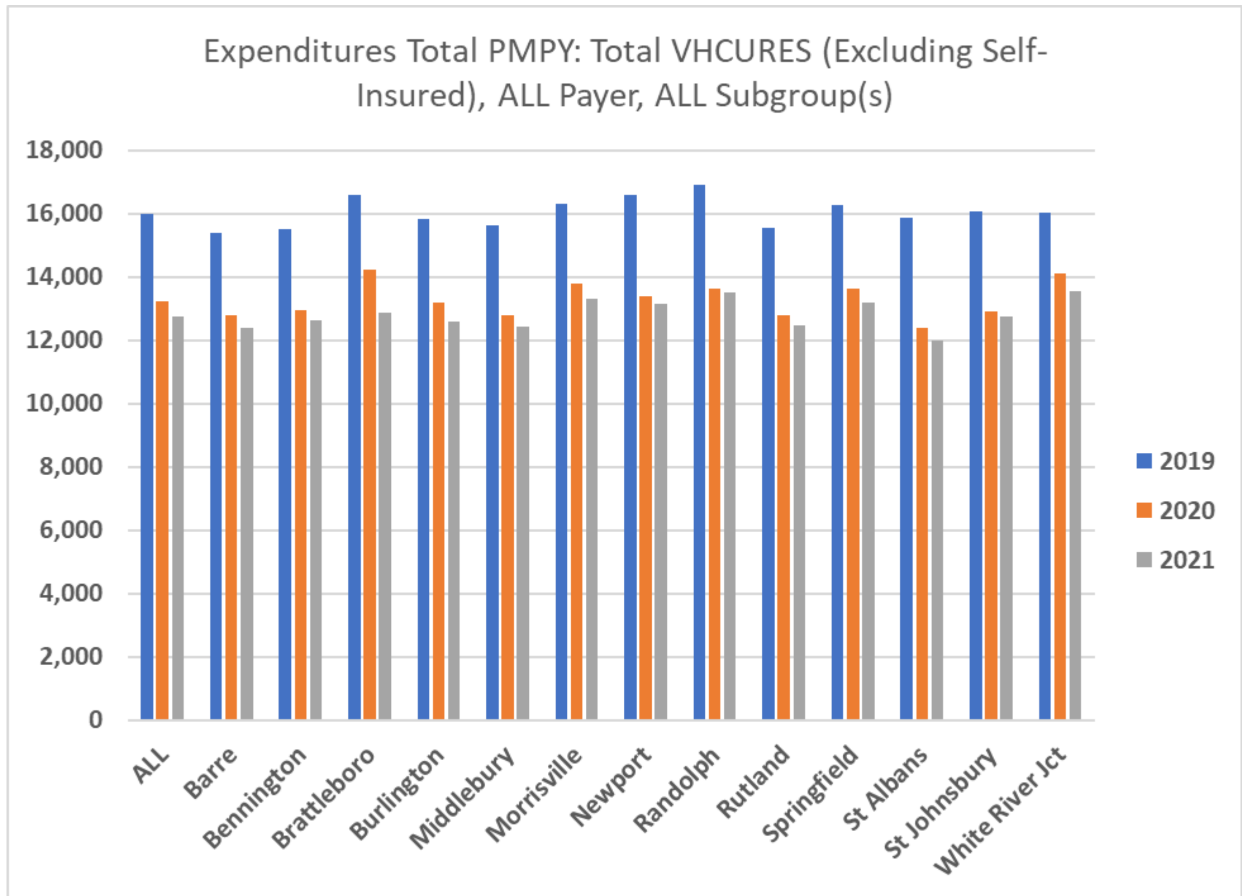
Total VHCURES (Excluding Self-Insured) Population



Health Care Expenditures

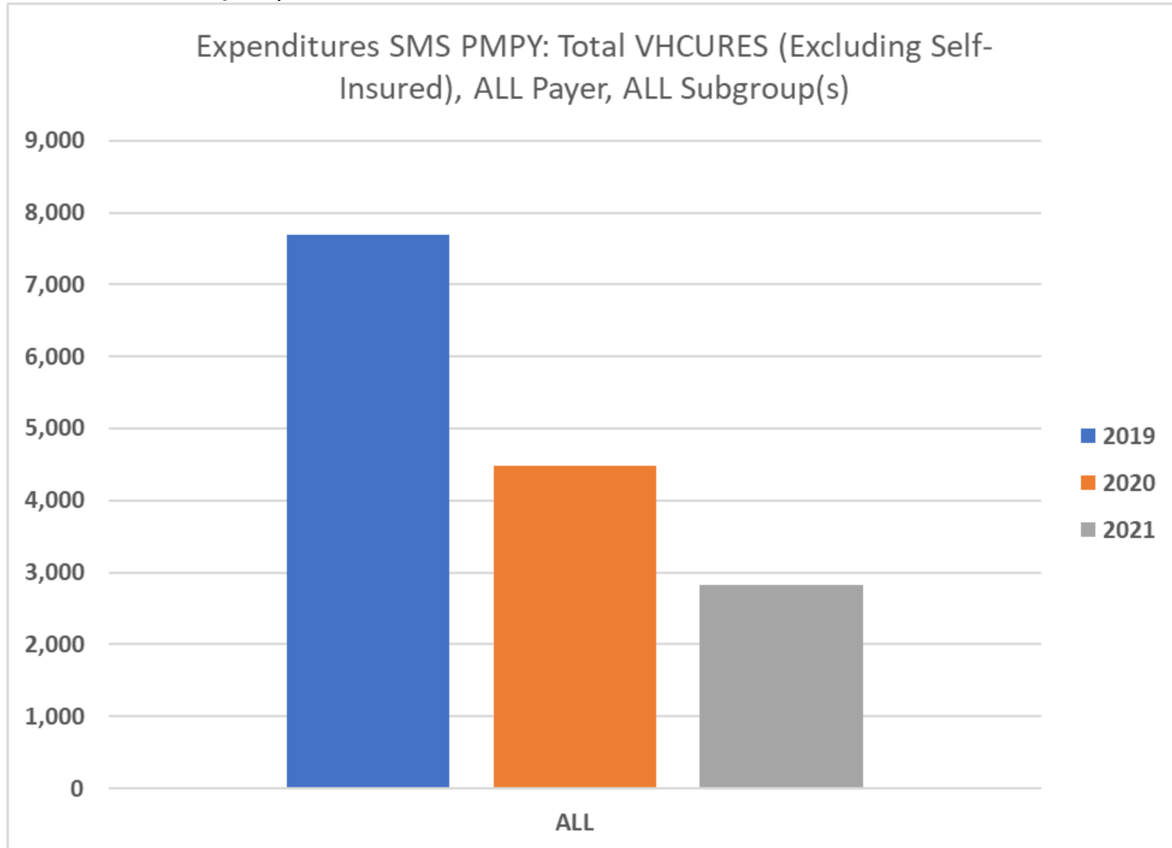
Expenditures Total Per Member Per Year, Risk-Adjusted, by HSA (Dollars, Inflation-Adjusted):

Total VHCURES (Excluding Self-Insured) Population



Expenditures Special Medicaid Services Per Member Per Year, Risk-Adjusted, Statewide (Dollars, Inflation-Adjusted):

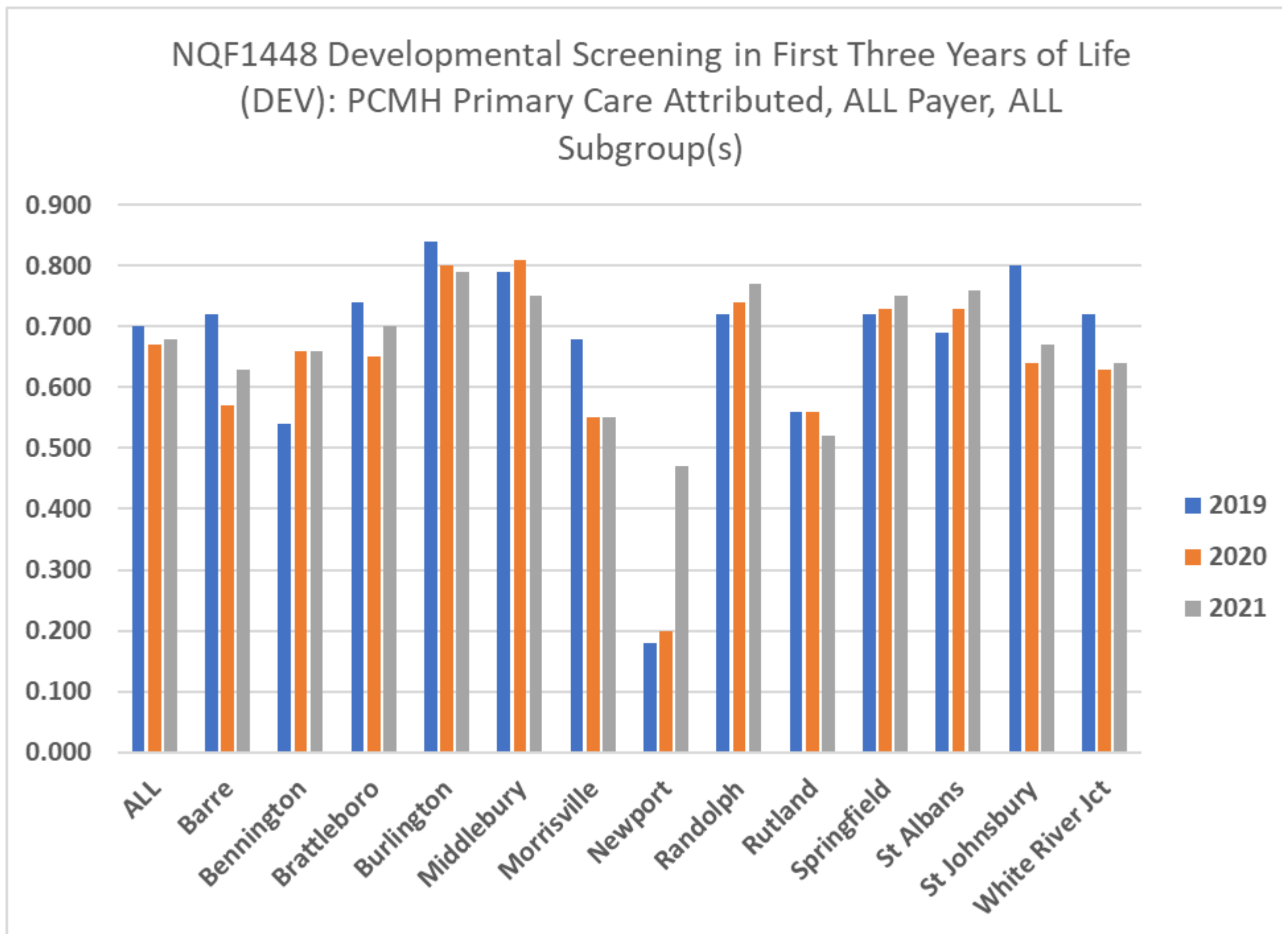
Medicaid-Primary Population



Health Care Quality Measures

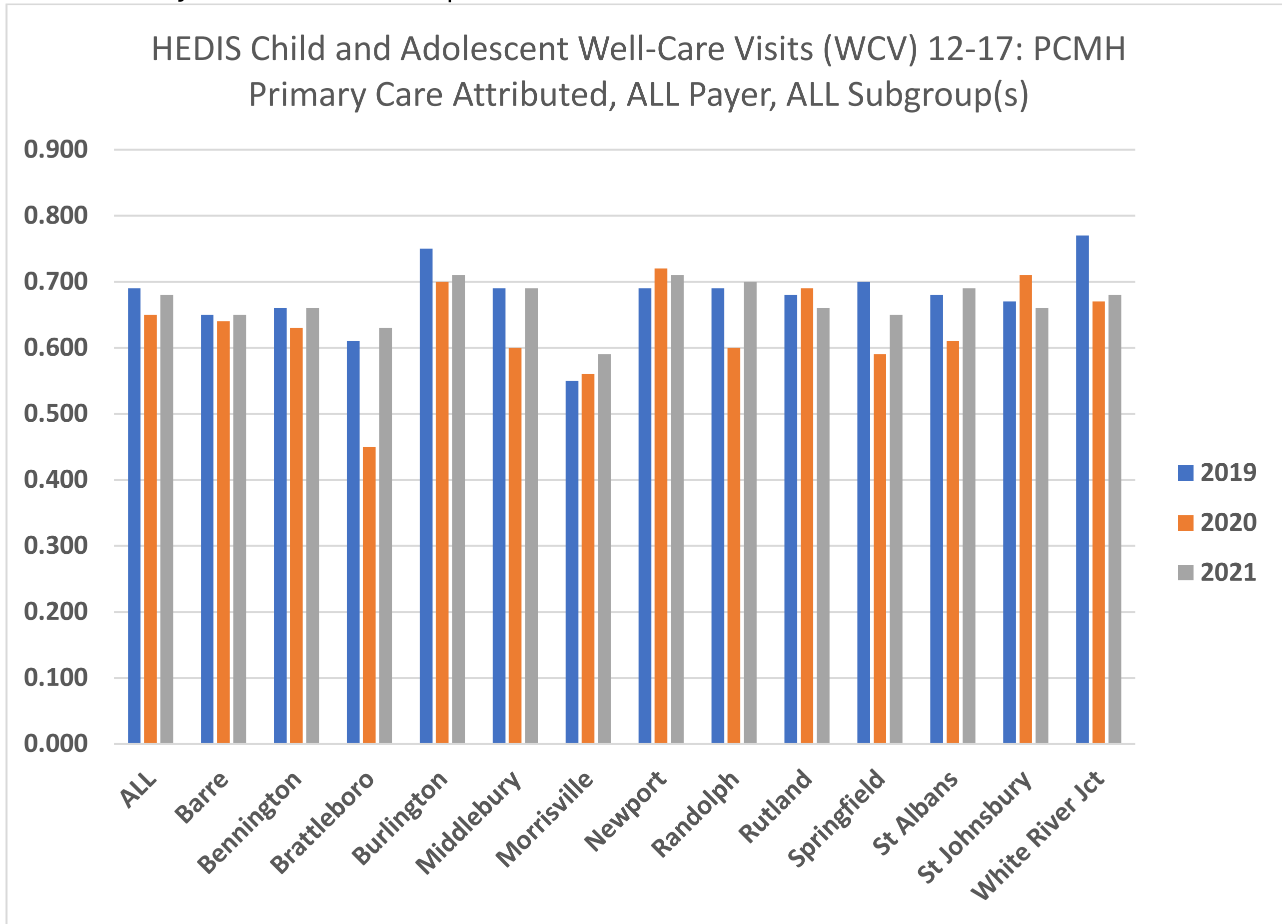
NQF1448 Developmental Screening in the First Three Years of Life (DEV), By HSA (Proportions):

PCMH Primary-Care-Attributed Population



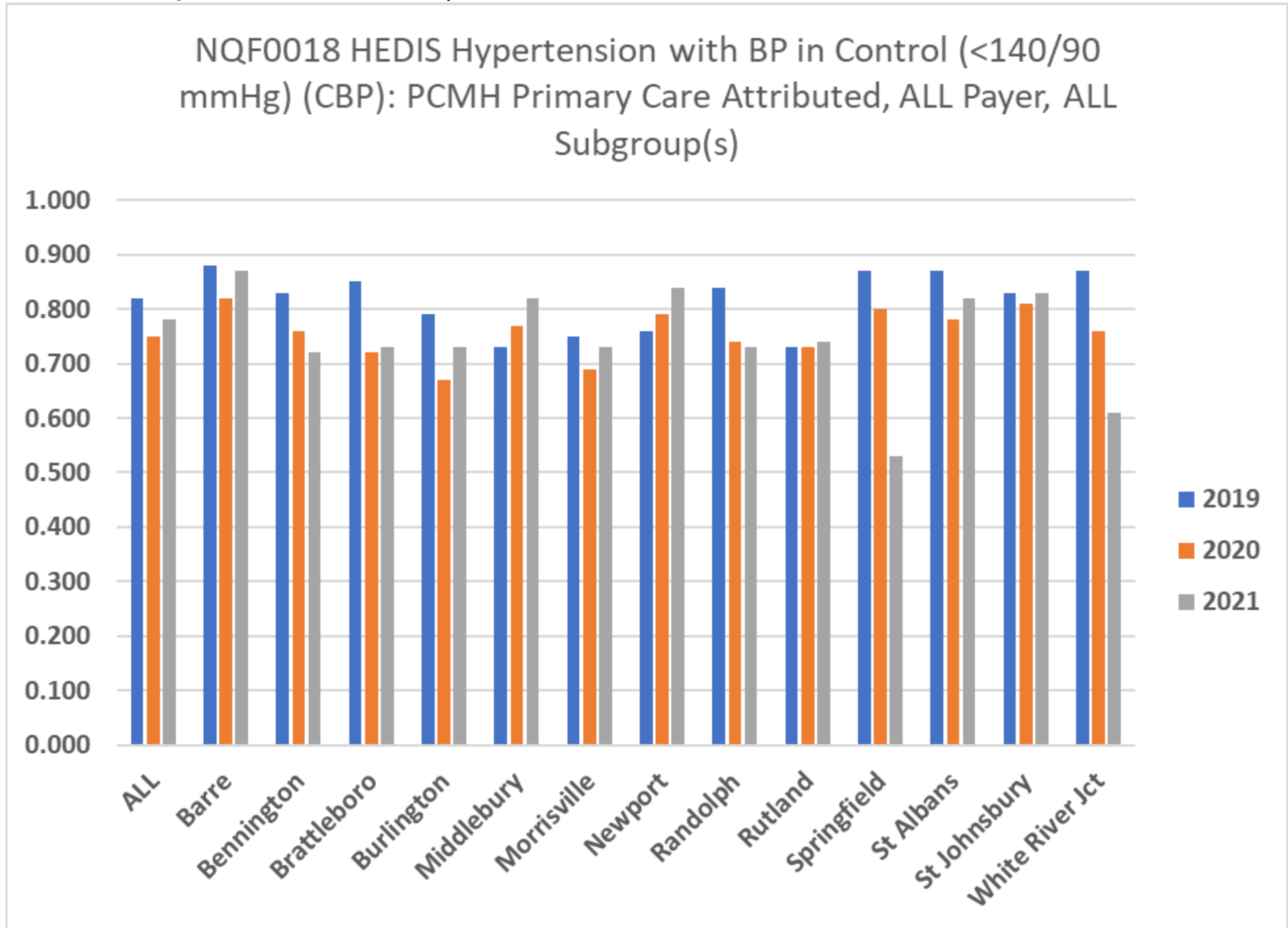
HEDIS Adolescent Well-Care (AWC) Visit 12-17 Years Old, By HSA (Proportions):

PCMH Primary-Care-Attributed Population



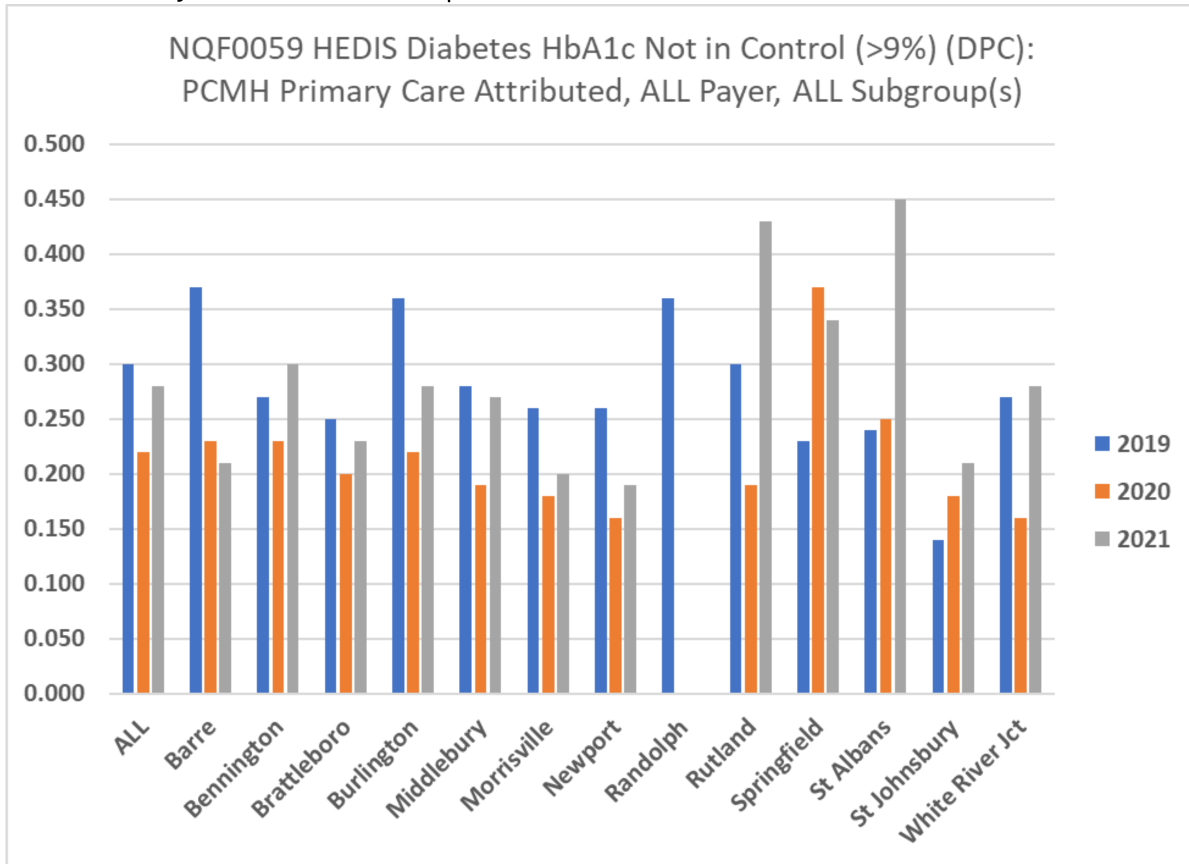
NQF0018 HEDIS Hypertension with Blood Pressure in Control (<140/90 mmHg) (CBP), By HSA (Proportions):

PCMH Primary-Care-Attributed Population



NQF0059 Diabetes HbA1c Not in Control (>9%) (DPC), By HSA (Proportions) [Lower is Better]:

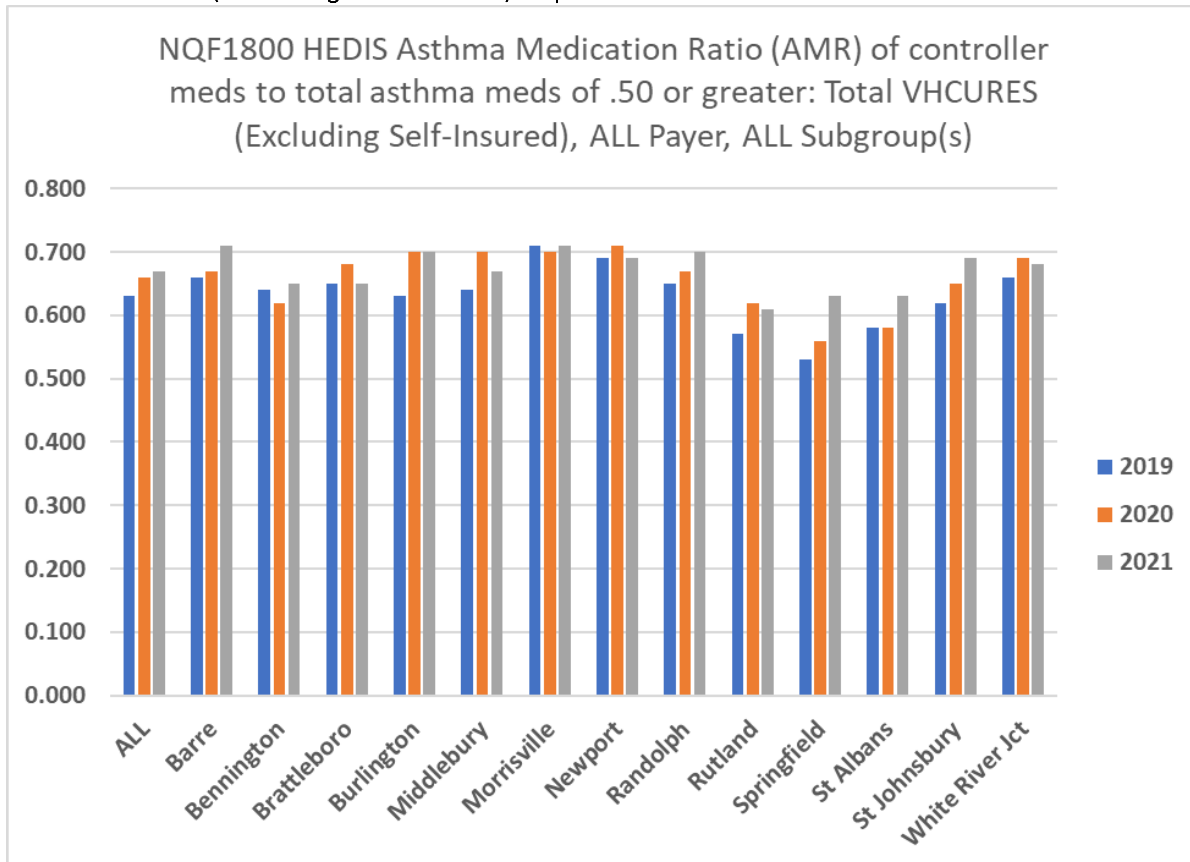
PCMH Primary-Care-Attributed Population



Other Chronic Conditions

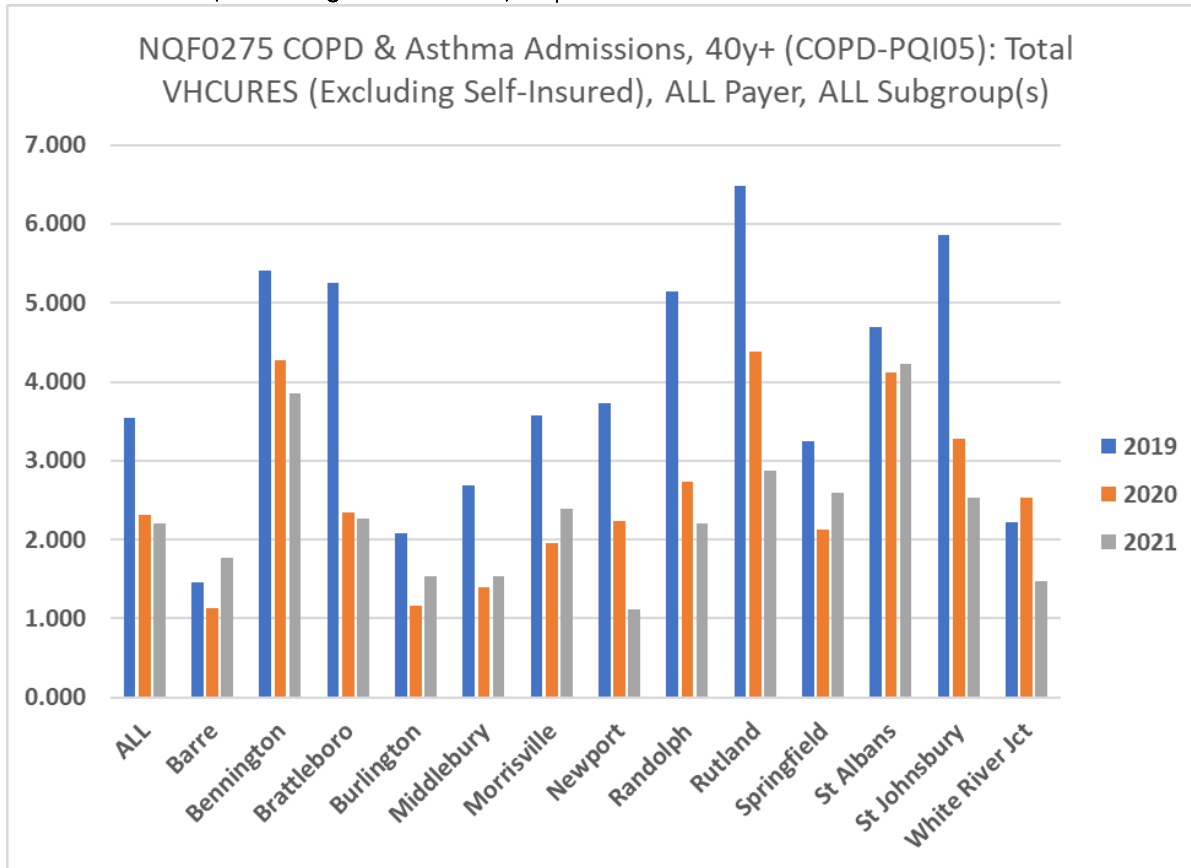
NQF1800 HEDIS Asthma Medication Ratio (AMR) of Controller Medications to Total Asthma Medications of .50 or Greater (Proportions), by HSA:

Total VHCURES (Excluding Self-Insured) Population



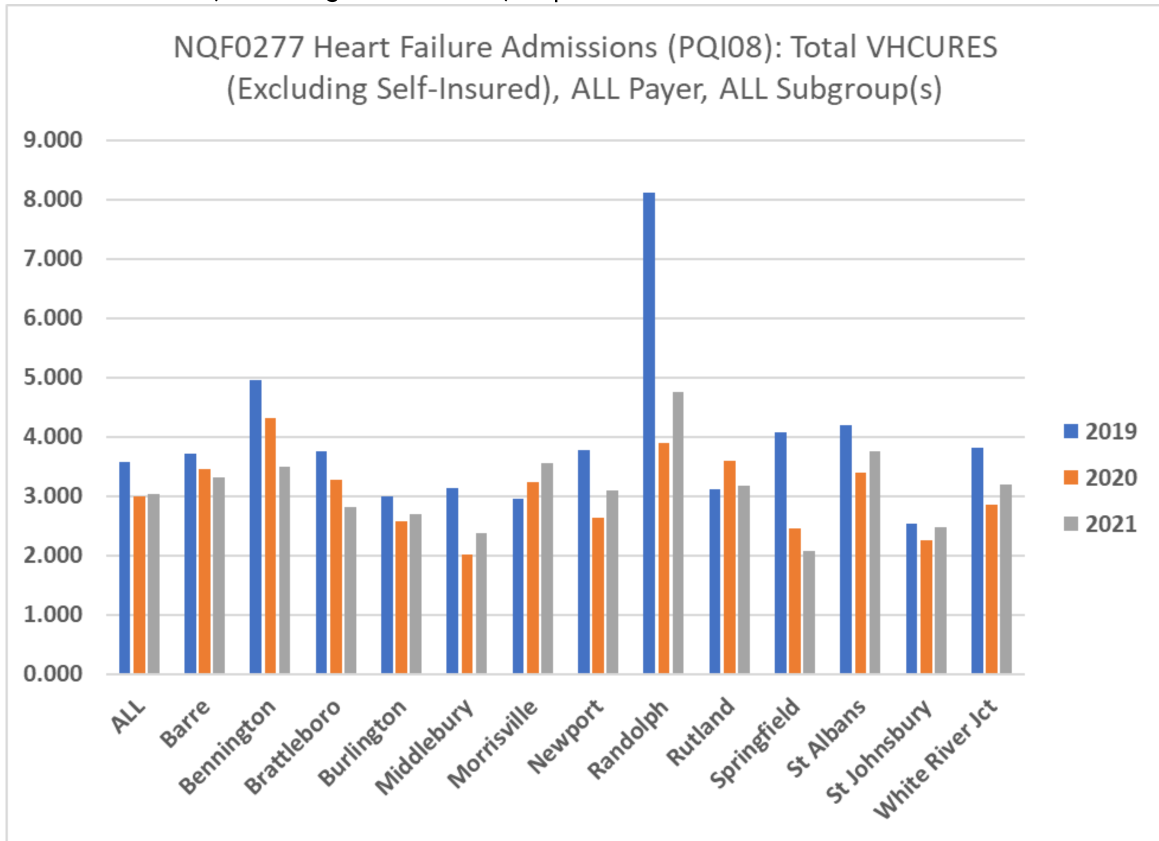
NQF0275 COPD & Asthma Admissions, 40 Years Old Plus (COPD-PQI05) (Admissions Per 100K Population), by HSA:

Total VHCURES (Excluding Self-Insured) Population



NQF0277 Heart Failure Admissions (PQI08) (Admissions Per 100K Population), by HSA:

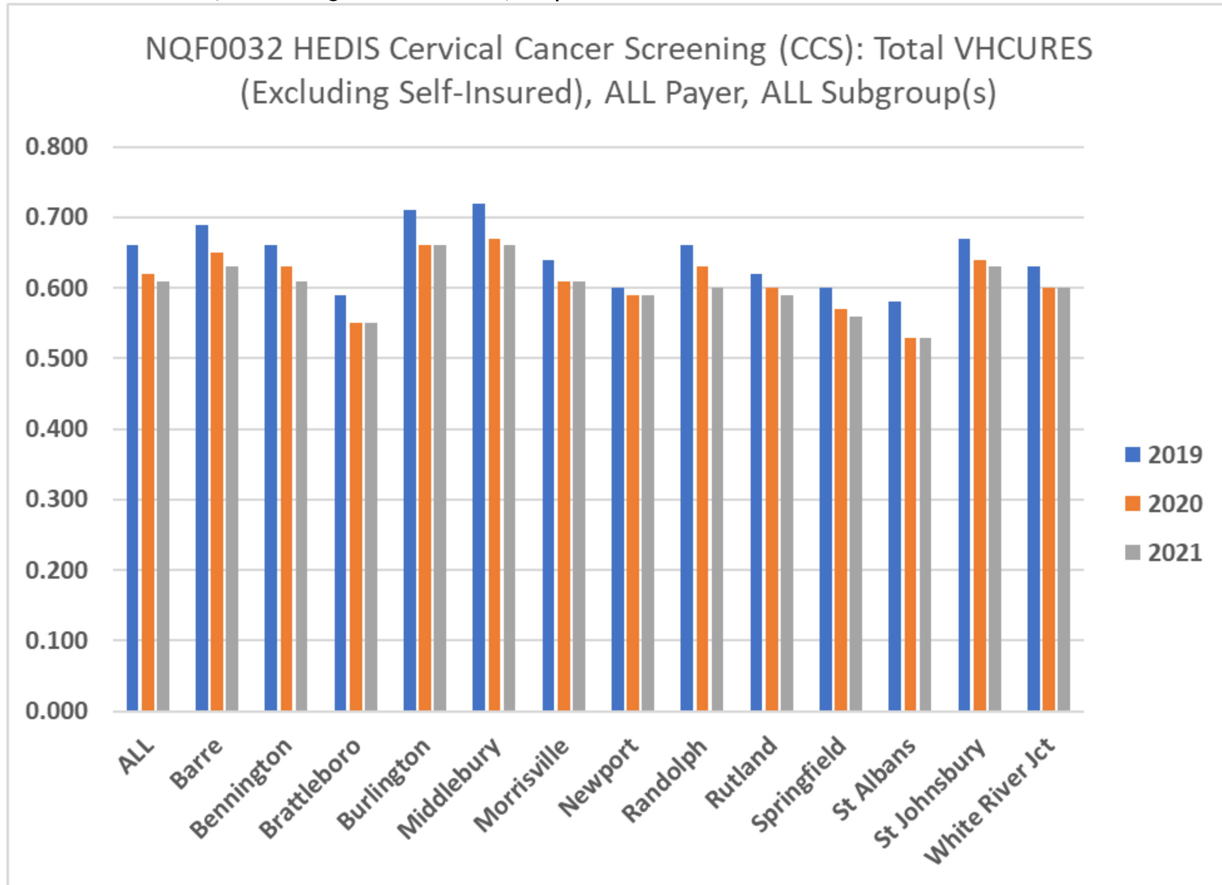
Total VHCURES (Excluding Self-Insured) Population



Women's Preventative Health Care Measures

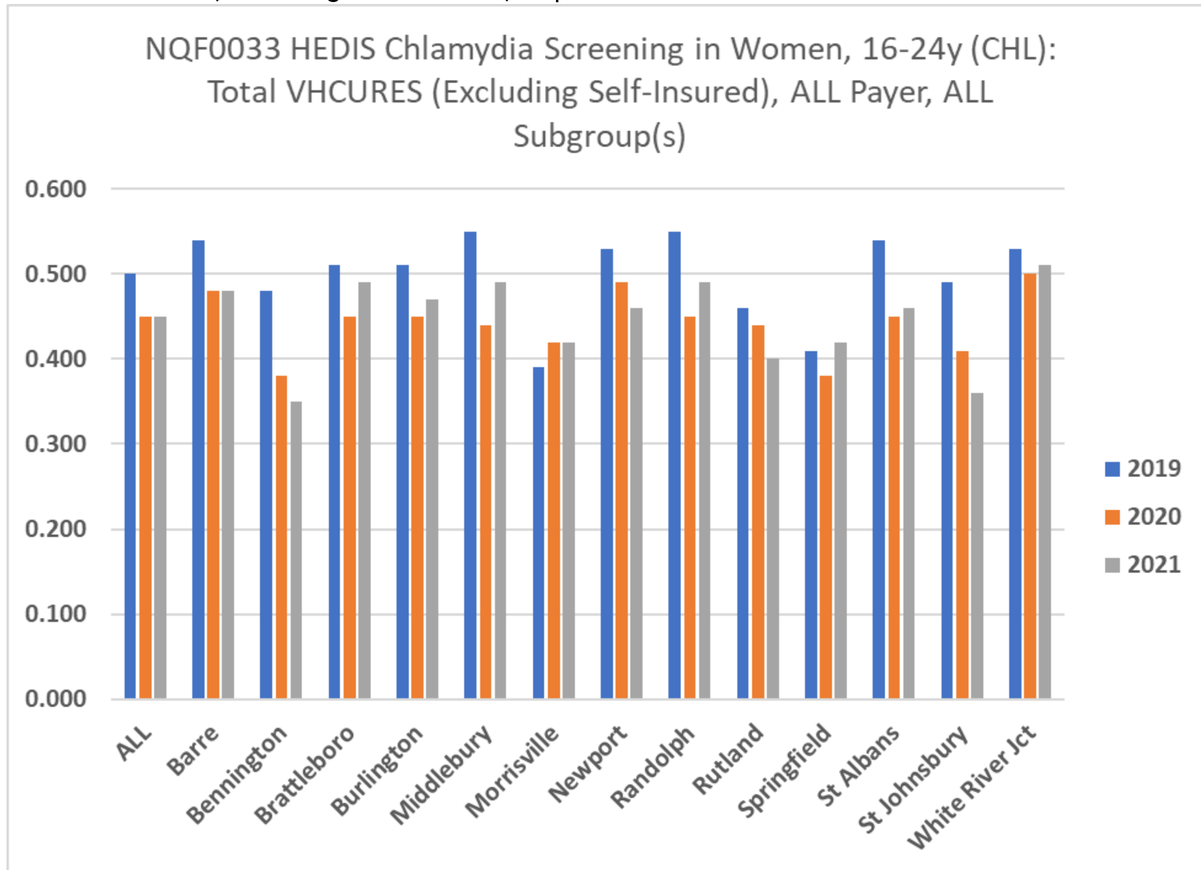
NQF0032 HEDIS Cervical Cancer Screening (CCS) (Proportions), by HSA:

Total VHCURES (Excluding Self-Insured) Population



NQF0033 HEDIS Chlamydia Screening in Women, 16-24 Years Old (CHL) (Proportions), by HSA:

Total VHCURES (Excluding Self-Insured) Population

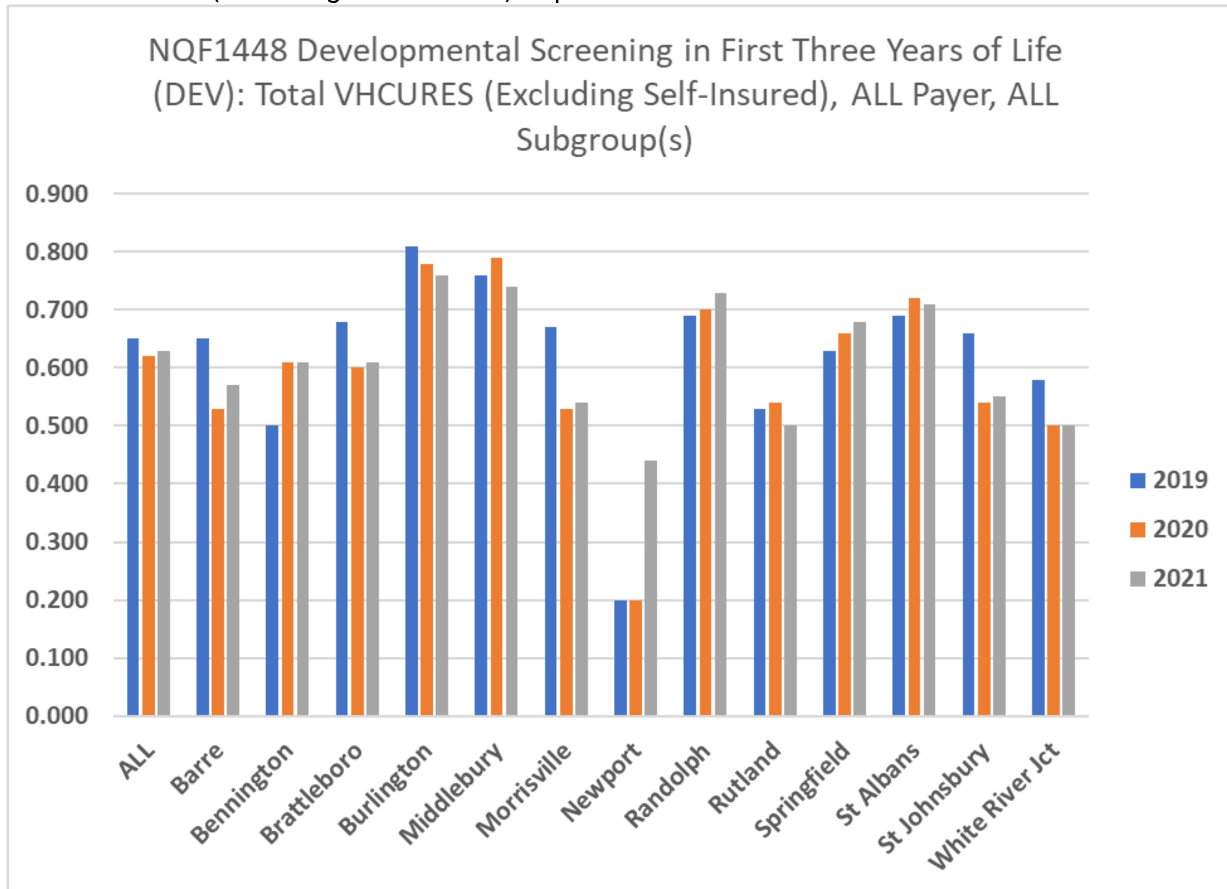


Access-To-Care and Health Care Utilization Measures

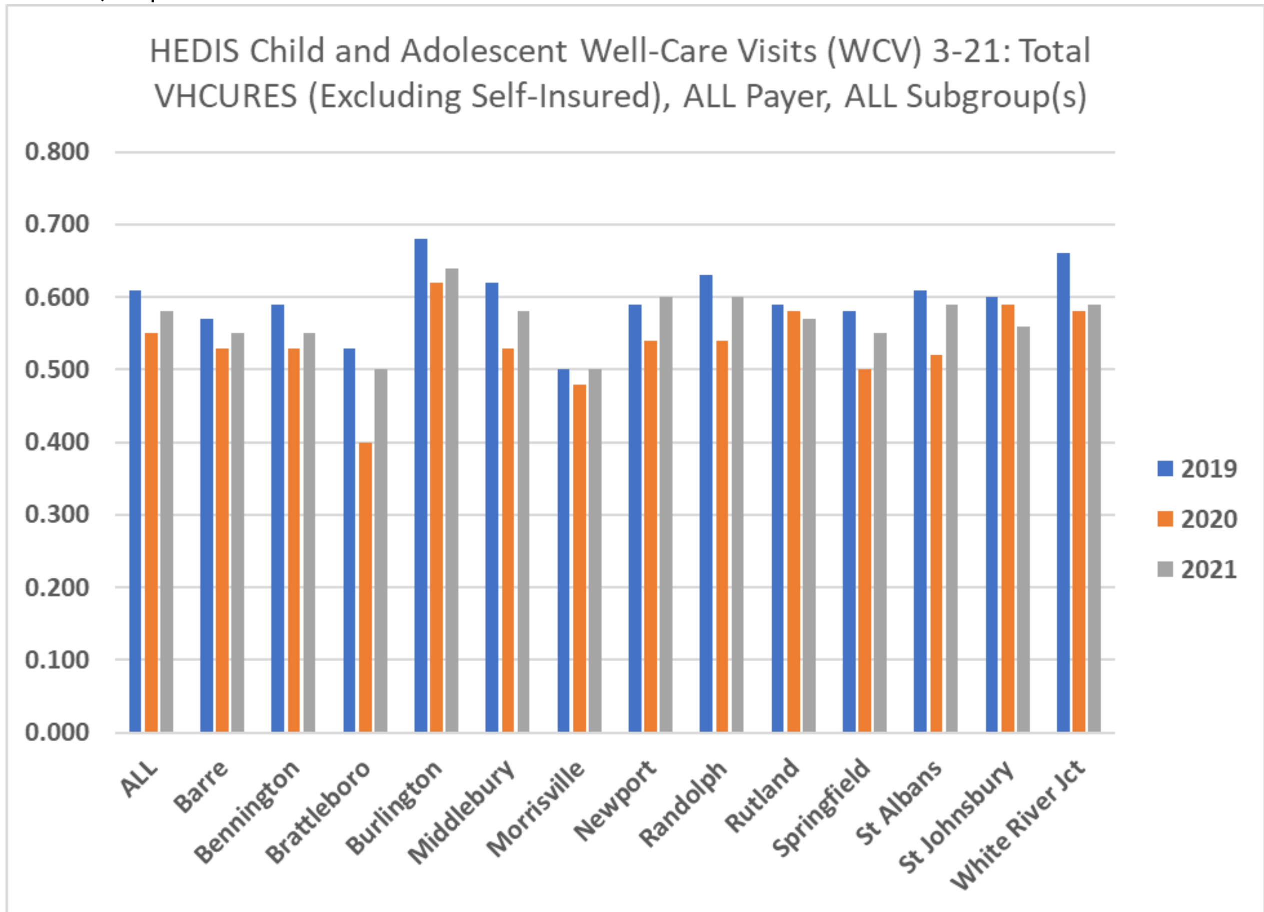
As stated above, 65.1% of VHCURES members who received primary care services were served by PCMHs in CY 2021. 91.0% of VHCURES members had a primary care visit during CY 2021, which was a decrease from 92.0% in CY 2020.

NQF1448 Developmental Screening in the First Three Years of Life (DEV), (Proportions), by HSA:

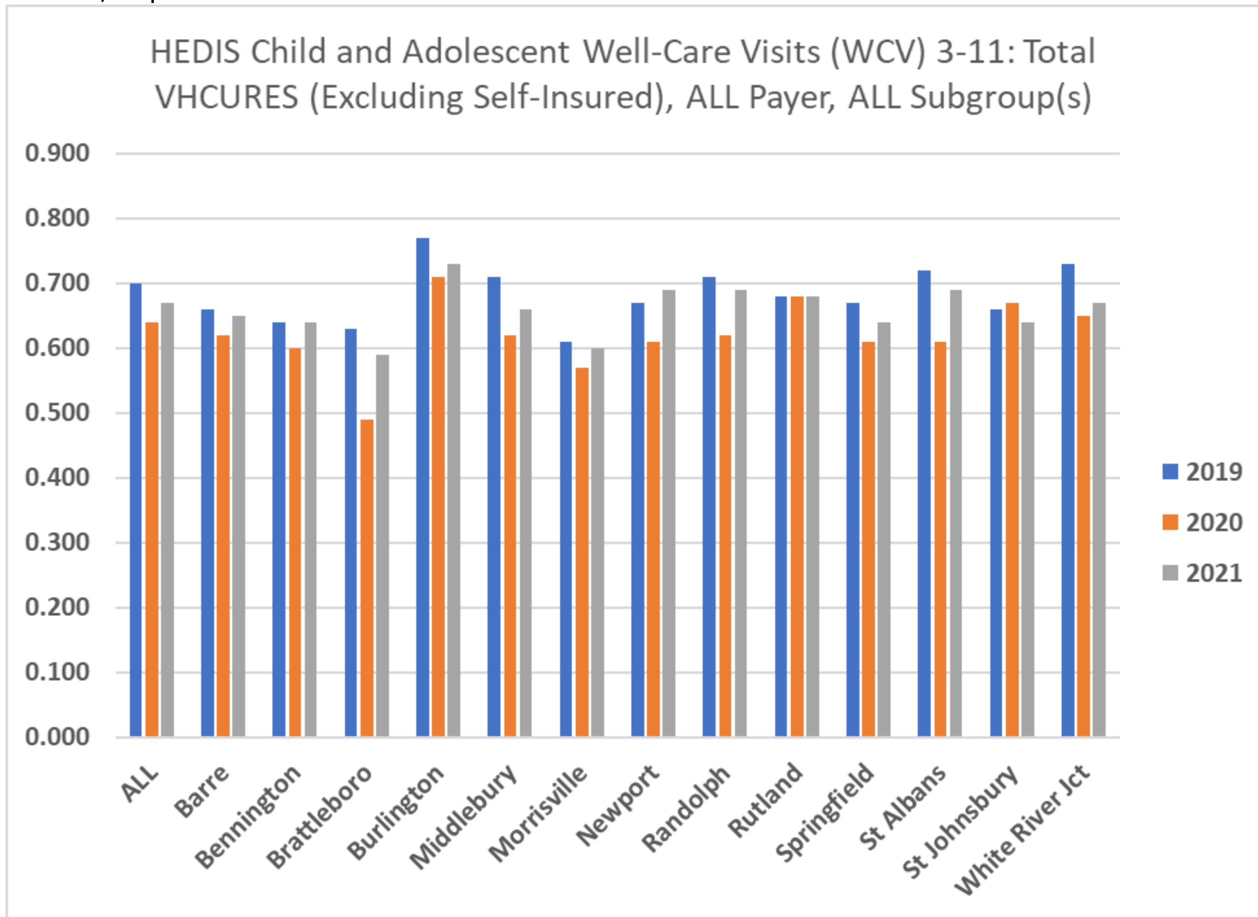
Total VHCURES (Excluding Self-Insured) Population



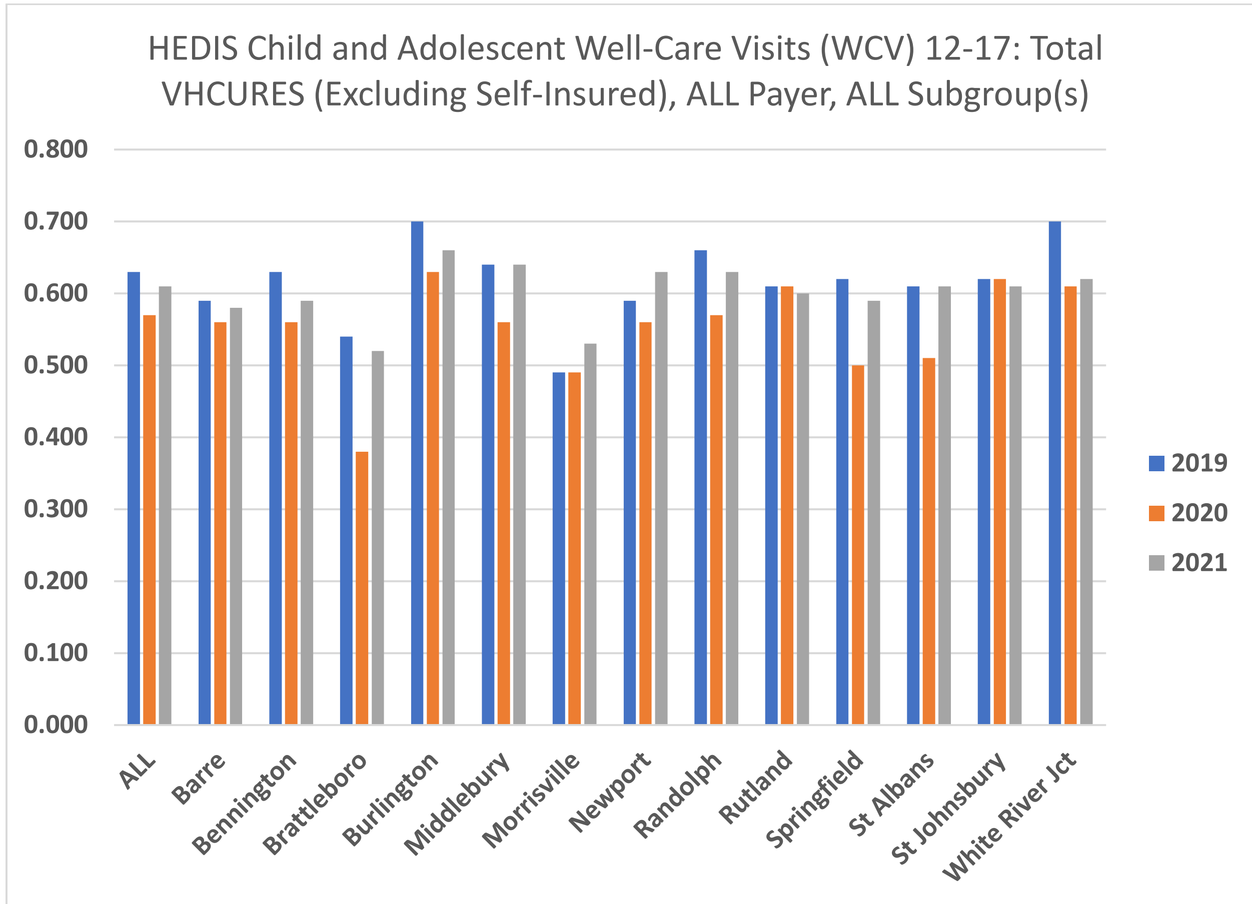
HEDIS Child and Adolescent Well-Care Visits (WCV) 3-21, by HSA: Total VHCURES (Excluding Self-Insured) Population



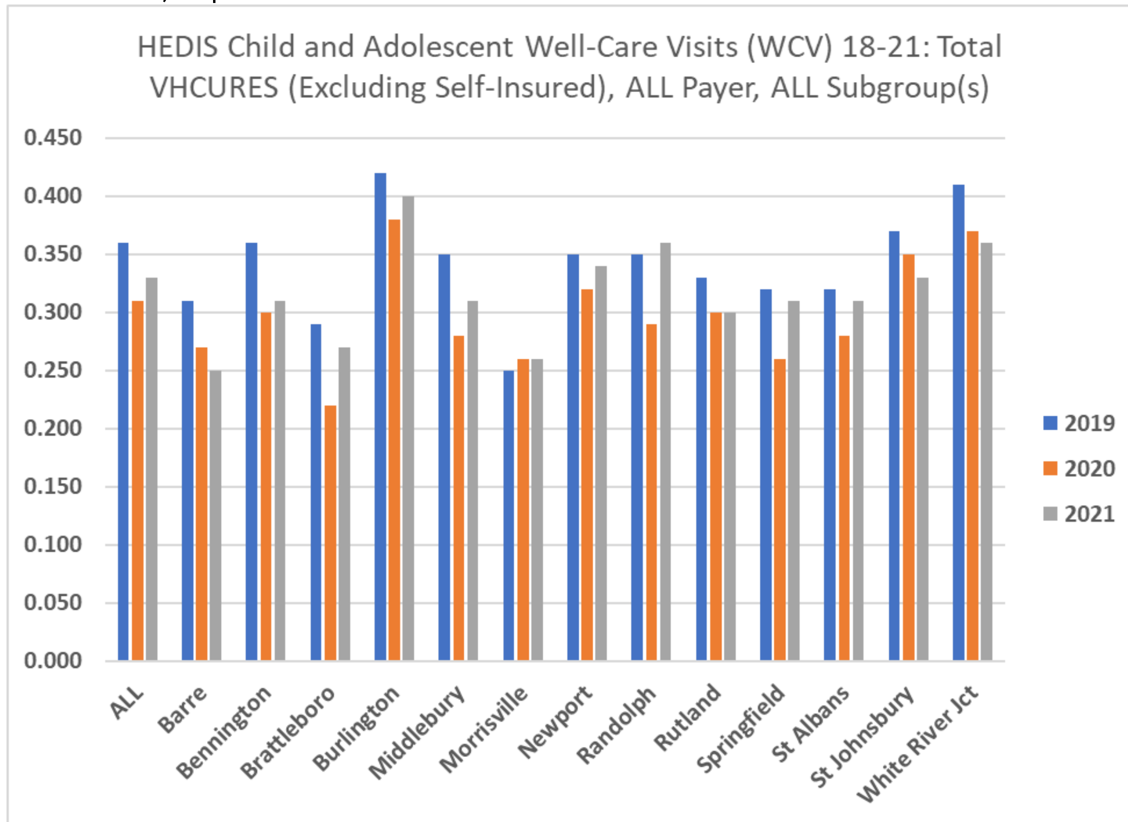
HEDIS Child and Adolescent Well-Care Visits (WCV) 3-11, by HSA: Total VHCURES (Excluding Self-Insured) Population



HEDIS Child and Adolescent Well-Care Visits (WCV) 12-17: Total VHCURES (Excluding Self-Insured) Population

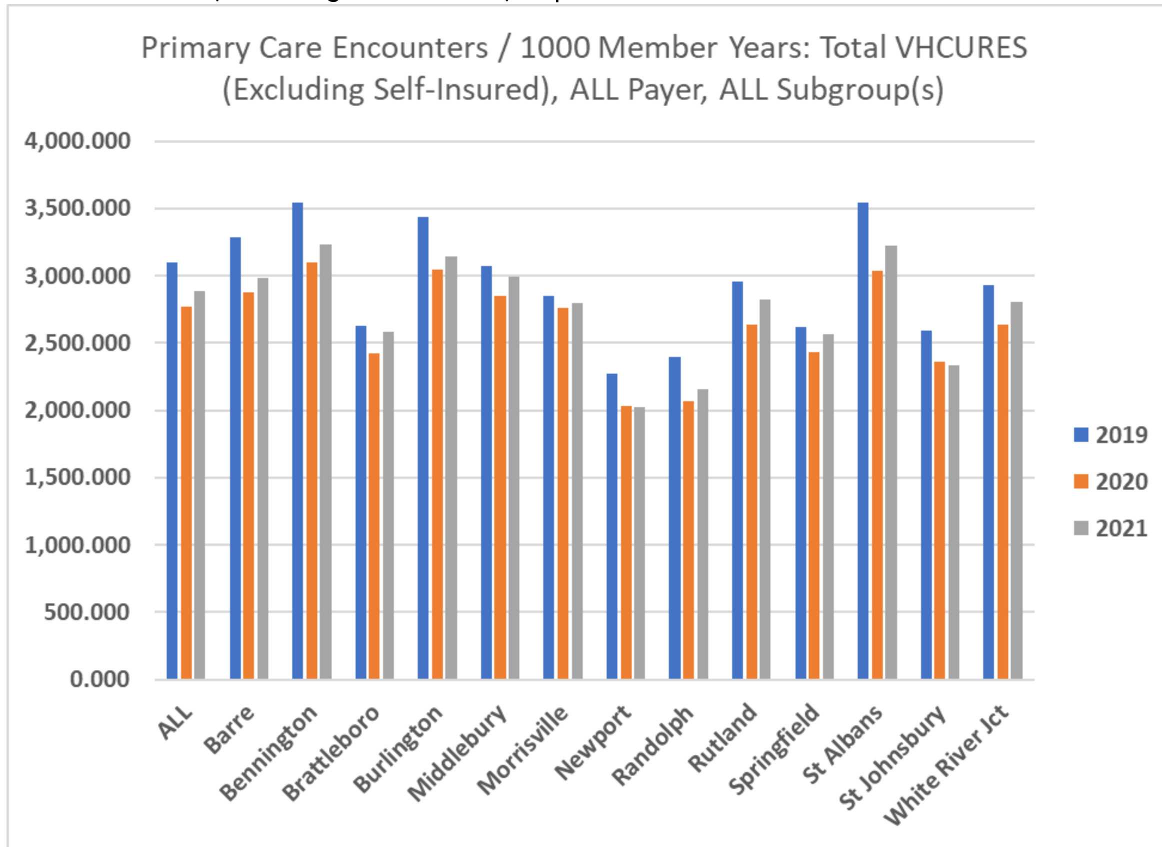


HEDIS CHILD and Adolescent Well-Care Visits (WCV) 18-21, by HSA: Total VHCURES (Excluding Self-Insured) Population



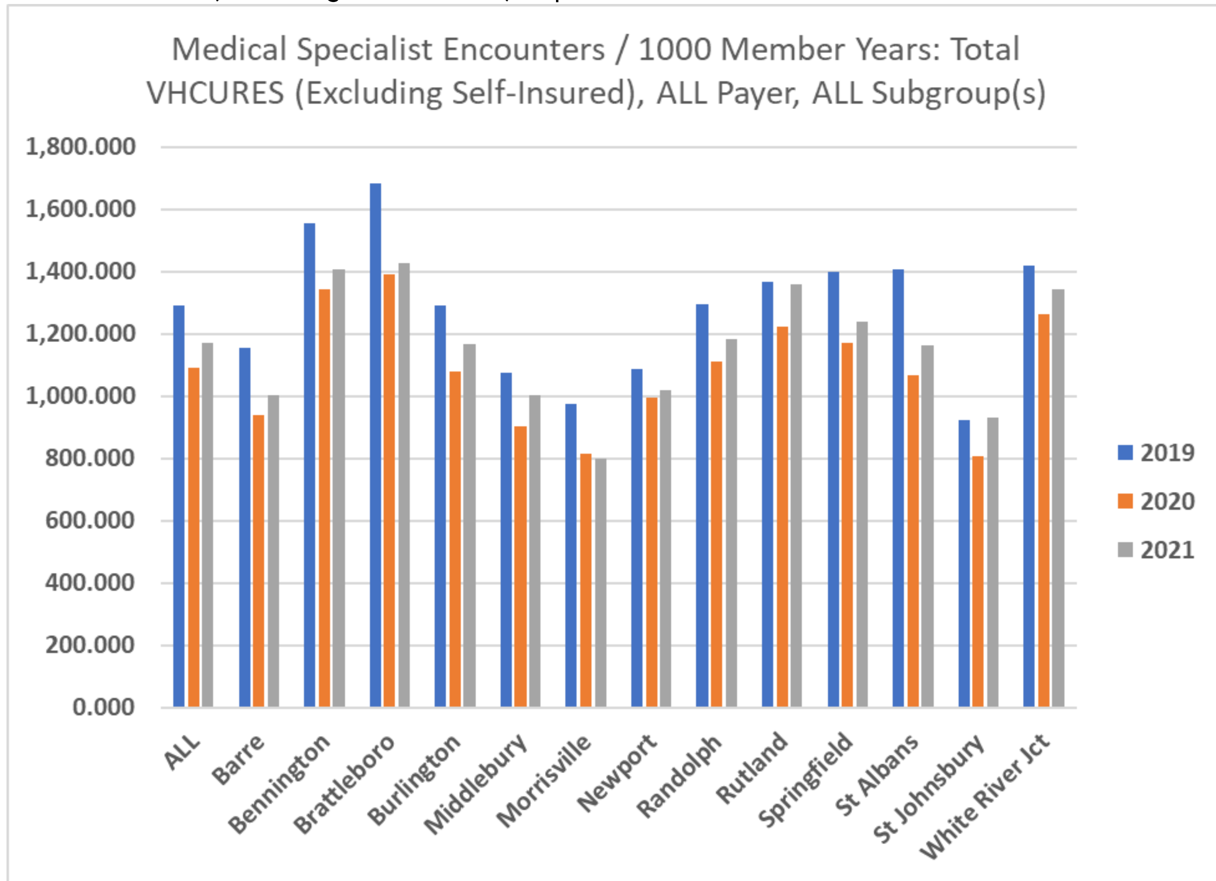
Primary Care Encounters / 1000 Member Years, Risk-adjusted, by HSA:

Total VHCURES (Excluding Self-Insured) Population



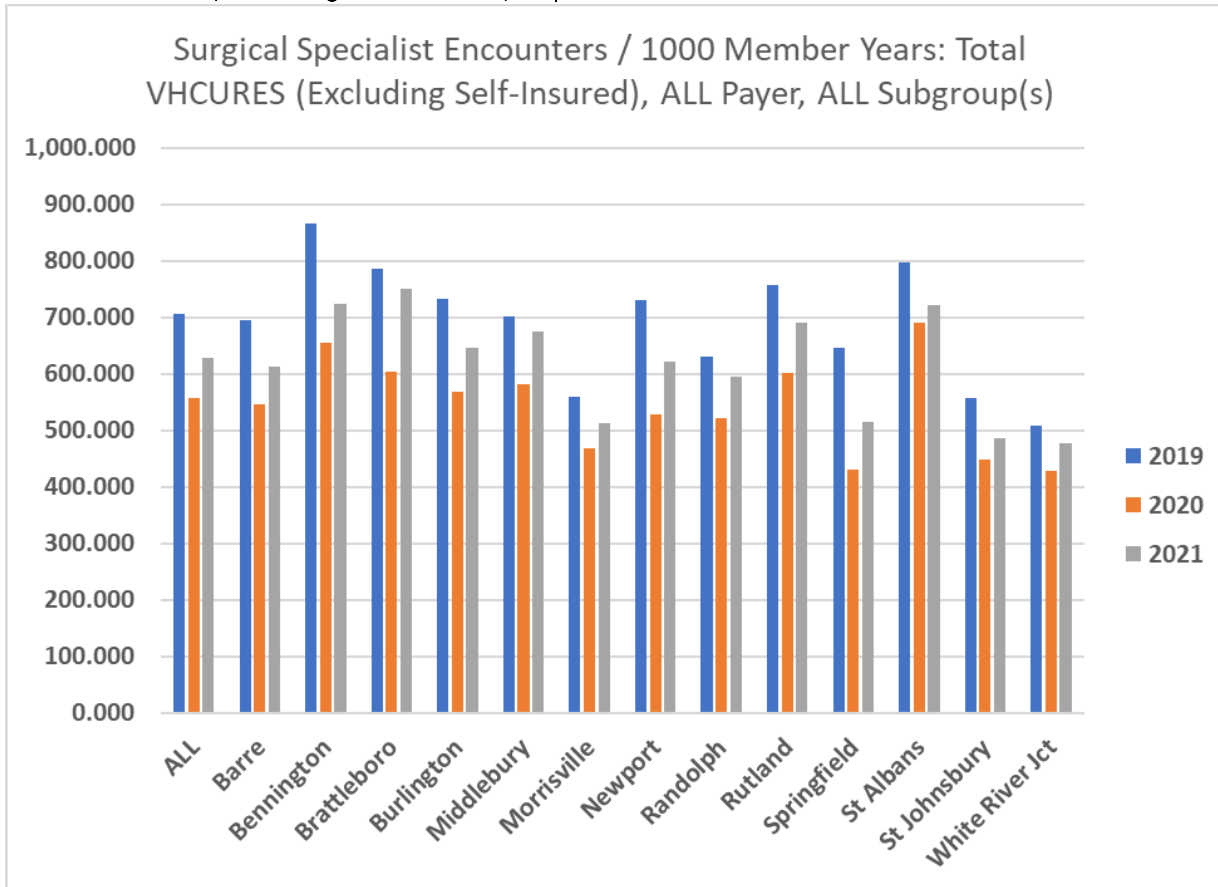
Medical Specialist Encounters / 1000 Member Years, Risk-adjusted, by HSA:

Total VHCURES (Excluding Self-Insured) Population



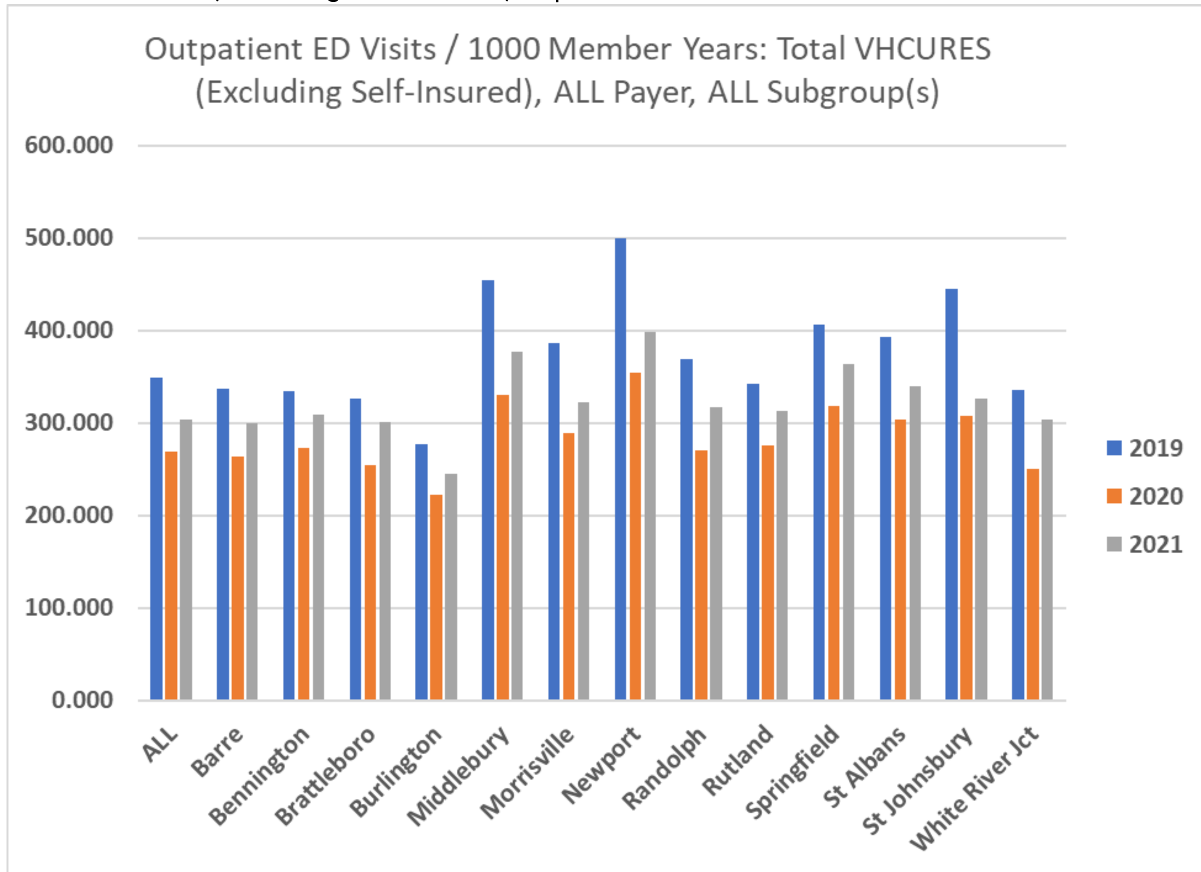
Surgical Specialist Encounters / 1000 Member Years, Risk-adjusted, by HSA:

Total VHCURES (Excluding Self-Insured) Population



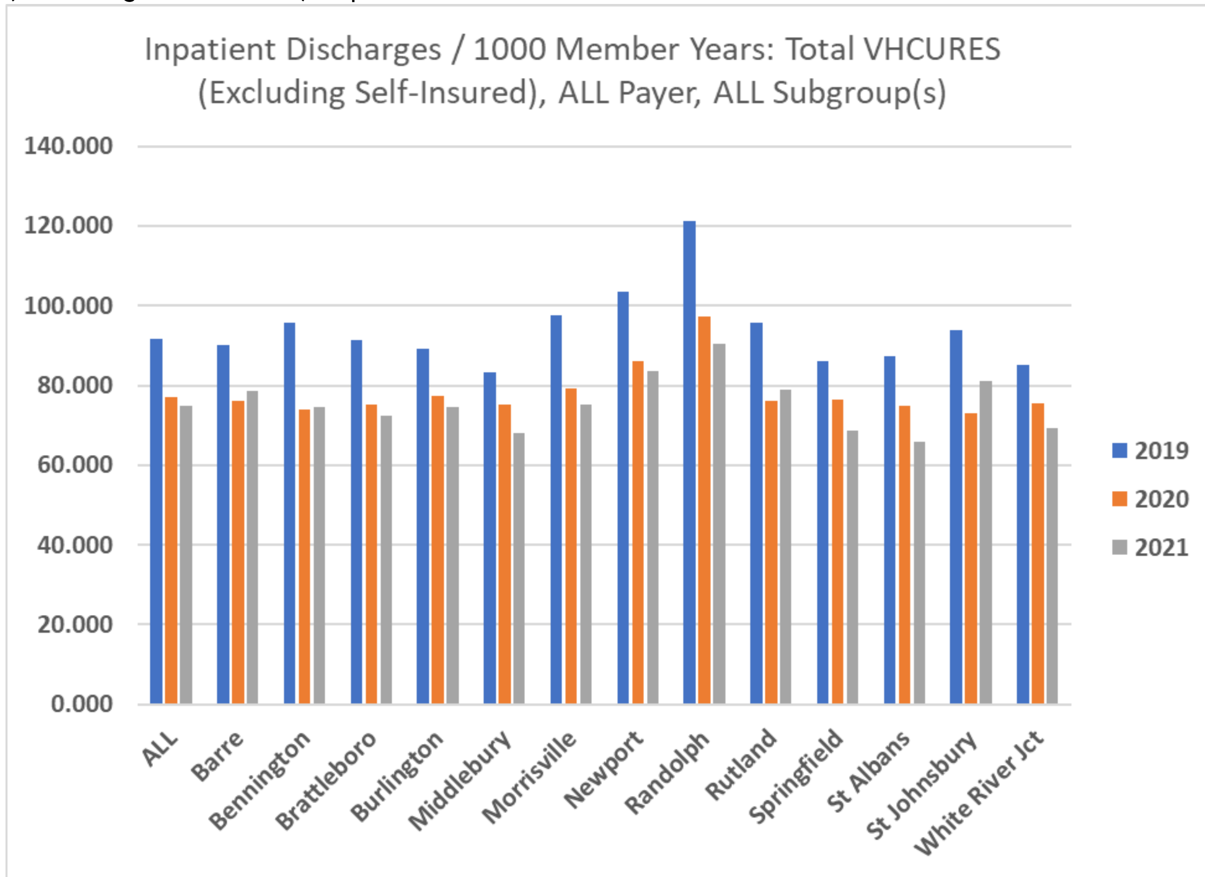
Outpatient Emergency Department Visits / 1000 Member Years, Risk-Adjusted, by HSA:

Total VHCURES (Excluding Self-Insured) Population



Inpatient Discharges / 1000 Member Years, by HSA: Total VHCURES

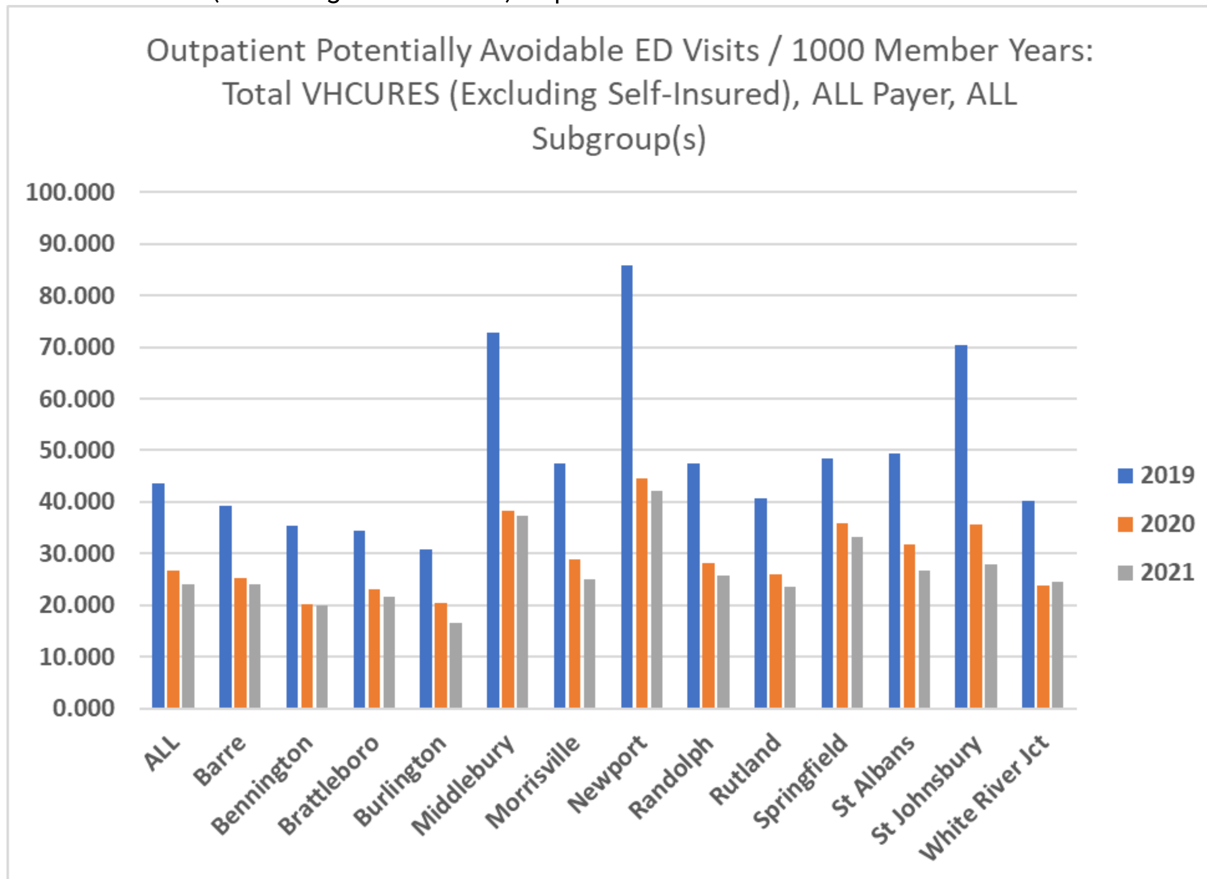
(Excluding Self-Insured) Population



Measures of Potentially Low-Value Health Care Utilization

Outpatient Potentially Avoidable Emergency Department Visits / 1000 Member Years, Risk-adjusted, by HSA:

Total VHCURES (Excluding Self-Insured) Population



PQI92 Chronic Composite - Ambulatory Care Sensitive Condition Inpatient Discharges / 1000 Member Years, Risk-Adjusted, by HSA:

Total VHCURES (Excluding Self-Insured) Population