Community Health Team Expansion
July 2024-June 2025 Practice Attestation

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

Attesting for multiple practices ☐ yes ☐ no

Practice Name(s):

Street Address:

City, State, ZIP Code:

Office Telephone:

Primary Contact Name and Title:

Primary Contact E-Mail Address:

Goal of Blueprint CHT Expansion:

Vermont is experiencing increased deaths from drug overdose and suicide and concerning levels and acuity of mental health and substance use disorders. There is a need to broaden screening for and addressing social determinants of health, mental health, and substance use disorders. The objective of this project is to ensure that screening, brief intervention, and navigation to services occurs across the entire population served by Blueprint Patient-Centered Medical Homes (PCMHs).

Practice Commitment

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

- Incorporate the Community Health Team (CHT) member into the patient's care team in support of expansion goals and strategies. CHT members will be embedded and integrated in the practice to the greatest extent possible for screening, assessment, intervention, and management of care interventions related to mental health, substance use, and social need. CHT members are not able to bill for these services. The practice agrees to report the information detailed in the Reporting, Evaluation, and Measurement section related to CHT staffing to Program Manger prior to the fifteenth (15th) day of the first month of each calendar quarter ongoing July, October, January, and April.

- Engage with Quality Improvement Facilitator(s) to implement the pilot goals and strategies and conduct continuous quality improvement activities. The practice will meet no less than once a month with their assigned Quality Improvement Facilitator to support implementation activities, including tracking data and conducting regular analysis to identify opportunities for interventions and improved outcomes.
- Participate in educational opportunities offered by the Blueprint for Health related to mental health and substance use screening and treatment in primary care settings as much as possible. The practice will engage in offerings, such as Academic Detailing or Learning Collaboratives, offered by the Blueprint for Health.
- Participate in requested activities (i.e. reporting, chart review, survey(s), focus groups, and support for patient/family recruitment for interviews) to evaluate pilot processes and outcomes. If using the Quality Improvement Facilitator to assist with chart review, the practice agrees to execute a memorandum of understanding (MOU) or a business associate agreement (BAA) with the Quality Improvement Facilitator for sharing protected health information.

Staff types: The Administrative entity Program Manager will engage with all Blueprint primary care practices to utilize additional funding with the following ratio of Medicaid patients to hire a licensed or unlicensed Mental Health Counselor, Social Worker, Community Health Worker, Certified drug and alcohol counselor, Licensed drug and alcohol counselor, Psychologist, or Family Specialist as a member of the primary care team embedded in the practice to ensure the following staffing levels.

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

Attributions of Medicaid Patients to Practices will be maintained at the levels from Quarter 1 of 2023 for the first year of the pilot. At the beginning of the second year, Medicaid attributions will be recalculated; however, funding for staffing levels will only be adjusted upward for practices. Funding will not be adjusted downward for any practice, even if they have a decreased Medicaid attribution in Year 2, unless such a downward adjustment is requested by the practice.

CHT Expansion – Year Two Goal: Screenings

Every practice will utilize screening tools for mental health, substance use, and social determinant of health needs for caregivers, families, individuals based on recommendations by age range. Practices will work towards implementing as many as possible over Year 2 of the CHT expansion. The National Committee for Quality Assurance (NCQA) requires a comprehensive patient assessment be completed for all patients which includes an examination of the patient's social and mental health influences in addition to a physical

health assessment which all PCMHs currently attest to meeting.

The Blueprint will provide a comprehensive Excel spreadsheet (Blueprint CHT Expansion Pilot Screening Tool Spreadsheet) that is populated with suggested screening tools per age group and key domain areas.

Each participating practice will report current screening tools or questions being asked per practice (or per group of practices) with support from the Blueprint Program Manager and/or Quality Improvement Facilitator. If none of the screening tools are being used in a domain, this should be entered. The completed spreadsheet will be sent to the Blueprint Program Manager to share with the Blueprint central office. This allows Blueprint to support the practice and understand the landscape of screenings used. This information must be submitted by May 15, 2024.

The Blueprint CHT Expansion Pilot Screening Tool Spreadsheet has instructions and links to tools. The links are also included at the bottom of this document. This spreadsheet is categorized by Domain Area, Age Range, with Patient Screening and/or Caregiver Screening recommendations.

Social Determinants of Health (SDOH): CMS Health-Related Social Needs Accountable Health Communities (AHC) tool. Domains across the age range as identified on spreadsheet. For **caregivers,** the Blueprint is asking that a minimum 4 domains—Food, Family/Community support, Mental Health, Substance Use—be in use by the end of year 2 of the pilot. Practices may use the AHC tool OR other tools to assess those domains. For **patients ages 18 and olde**r, the Blueprint is asking that the CMS tool be used for all domains—Questions 1-10, Questions 11-12, Questions 13-15. If not using this tool, the practice will enter the tool that is being used and/or if the questions are asked in another format. If not asking in that domain area, please note that with a "0".

Preventative Pediatric Health Care: Practices should follow the Developmental/Social/Behavioral/Mental Health section periodicity requirements (i.e. Maternal Depression Screening, Developmental Screening, Autism Spectrum Disorder Screening, Behavioral/Social/Emotional Screening, Tobacco, Alcohol, or Drug Use Assessment, and Depression and Suicide Risk Screening) from Bright Futures and American Academy of Pediatrics. Recommended tools that align with these requirements are listed on the CHT Expansion Pilot Screening Tool Spreadsheet.

Substance Use: Alcohol Use Disorder Test (AUDIT), Drug Abuse Screening Test (DAST), CRAFFT or UNCOPE which are administered according to evidence-based guidelines per age and whether for patient or caregivers. If another tool/question is utilized, this should be entered on spreadsheet.

Tobacco Screening: Administered per evidence-based guidelines.

Mental Health: Screening using the Patient Health Questionnaire PHQ2/PHQ9 and Adolescents (PHQ-9A) is conducted per evidence-based guidelines across the age range and for caregivers.

Suicide: Colum The Blueprint strongly suggests using the PHQ 9 and/or Columbia Suicide Severity Rating Scale (CSSR) screening in conjunction to address suicide risk. See instructions on spreadsheet.

Pregnancy Intention: For patients ages 15 and older, use **One Key Question (**Pregnancy intention in the next 12 months).

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

Reporting, Evaluation, and Measurement Participation – Year Two

1. Number of FTEs and staffing types hired with expansion funding submitted to the Blueprint Program Manager who will enter via Blueprint Portal.
2. Number of CHT unique patient counts by payer submitted to the Blueprint Program Manager who will enter via Blueprint Portal.
3. The practice agrees to participate in a chart review of 5 patients seen by the CHT between July – September 2024. Details of this requirement will be outlined to the practice in August 2024 and the chart review will be completed by a practice representative (who has attended required reviewer training) or Quality Improvement Facilitators in October 2024.
4. Practice staff may be asked to participate in focus groups or respond to surveys about the pilot and/or be asked to assist in recruiting patients and families to participate in focused interviews to evaluate the expansion pilot. The practice agrees to respond to requests for participation in these evaluation activities.

Blueprint for Health Commitment to Practices

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

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

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

This attestation is due to Blueprint Central Office by April 15, 2024

Practice:

Name of Signer (printed):

Title of Signer:

Signature:

Date:

Blueprint for Health, Health Service Area Program Manager:

Blueprint for Health Program Manager:

Name of Signer (printed):

Signature:

Date:

Scan and email to Blueprint Central office Nichole.Bachand@partner.vermont.gov

Evidence–Based Guidelines and Screening Resources:

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

Screening Tools:

1. The AHC Health-Related Social Needs Screening Tool (cms.gov)
2. CRAFFT
3. Edinburgh Postnatal Depression Scale (EDPS)
4. PHQ-9 modified for Adolescents (PHQ-A)
5. PHQ-2 and PHQ-9
6. Alcohol Use Disorders Identification Test (AUDIT)
7. Columbia Suicide Severity Rating Scale (CSSR)
8. dvha-screening-guidelines-and-tool-list.pdf (vermont.gov)
9. UNCOPE Screening Instrument for Substance Abuse (practicenotes.org)
10. One Key Question® Online 2024 | Power to Decide
11. mFTQ_measure.doc (live.com) Tobbacco Screen- Fagerstrom

Other Resources:

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