VERMONT

Blueprint for Health

Smart choices. Powerful tools.

PRESENTED BY:
ENTER NAME OF PRESENTER

AGENCY OF HUMAN SERVICES

The AHS Central Office, or
"The Secretary's Office"
Office of Health Care Reform

Lead by Jenney Samuelson, Secretary of the Agency of Human Services

Responsible for establishing and supporting the administration of policy, practice, fiscal, and operations across the Departments and District Offices

Ensures holistic, consistent, and reliable service delivery to Vermonters.

Departments: DAIL DCF DOC DMH DVHA VDH

BLUEPRINT FOR HEALTH CENTRAL OFFICE STAFF

WATERBURY, VERMONT

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Quality Improvement Coordinator

DR. MONIQUE THOMPSON

Specialty QI Facilitator

KARA HOOPER

Project Administrator

DR. MEREDITH MILLIGAN

Physician Clinical Consultant

EARLY HISTORY OF BLUEPRINT

2011 Act 128 shifts the Blueprint from a pilot to a statewide program

2010 Vermont is one of the eight states selected for CMS Multi-Payer Advanced Primary Care Practice Demonstration

2008 First pilot site: St. Johnsbury HSA

2007 ACT 71 establishes Medical Home and Community Health Teams

2006 Blueprint for Health codified into Vermont statute

EXPANSION OF BLUEPRINT

2023/2024 Practices attest and receive funding to be part of the CHT Expansion; staff hired to support mental health and substance use treatment and social drivers of health; integrate DULCE and develop pediatric model.

2023 Legislature approved funding for a Blueprint for a two-year Health Community Health Team Expansion Pilot

2022 Act 167 Requires recommendation on the amount to increase commercial insurer and Medicaid contributions to Community Health Teams and Quality Improvement Facilitation

2017 Pregnancy Intention Initiative (PII), formerly Women's Health Initiative (WHI)

2013 Hub and Spoke program for Opioid Treatment and Office Based Opioid Treatment

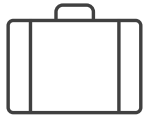
ACT 128

“integrating a system of health care for patients, improving the health of the overall population, and improving control over health care costs by promoting health maintenance, prevention, and care coordination and management.”

2010 Vermont Statutory Framework

Act 128 Mission of Blueprint For Health

BLUEPRINT EXECUTIVE COMMITTEE



PROVIDE

high-level multi-stakeholder guidance on complex issues

ADVISE

the Blueprint Director on strategic planning and implementation of health services with an emphasis on prevention

REPRESENT

a broad range of stakeholders

(health services, insurers, professional organizations, community & nonprofit groups, consumers, businesses, and state & local government)

COMMITTEE MAKEUP

AHS Members, Commissioner of MH, Private Health Insurers, Home Health, Self-Insured Employers, etc...

Full list available in Blueprint Manual

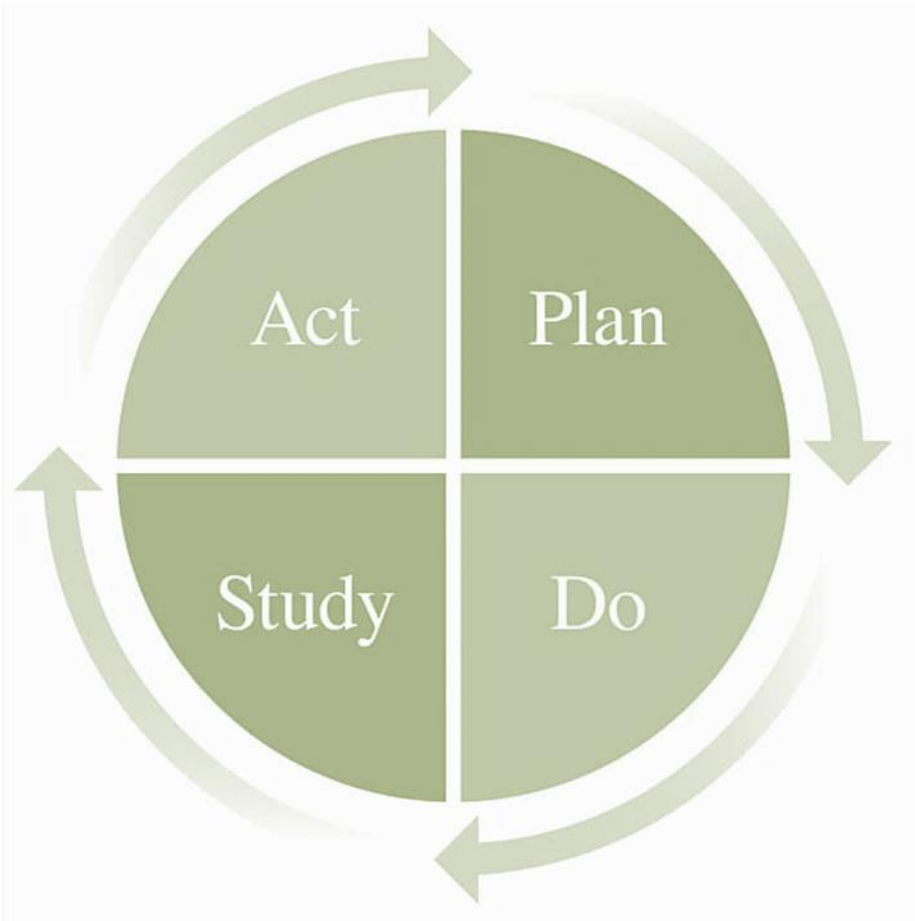
PATIENT CENTERED MEDICAL HOMES (PCMH)

A model of primary care delivery that seeks to provide accessible, comprehensive, whole-person-centered care in a coordinated and team-based fashion; typically allows for the provision of preventive care, acute and chronic disease management, and mental health care within a single setting

- Improved clinical outcomes
- Increased patient engagement in follow-up and treatment, and
- Decreased utilization of the emergency department in many studies

Must achieve and sustain recognition as a PCMH from the National Committee on Quality Assurance (NCQA)

Copy of Standards: http://www.ncqa.org



THE BLUEPRINT MODEL

IMPROVE POPULATION HEALTH

- Screening for Social Drivers of Health
- Support patient to manage Chronic Health Conditions

ENHANCE PATIENT EXPERIENCE

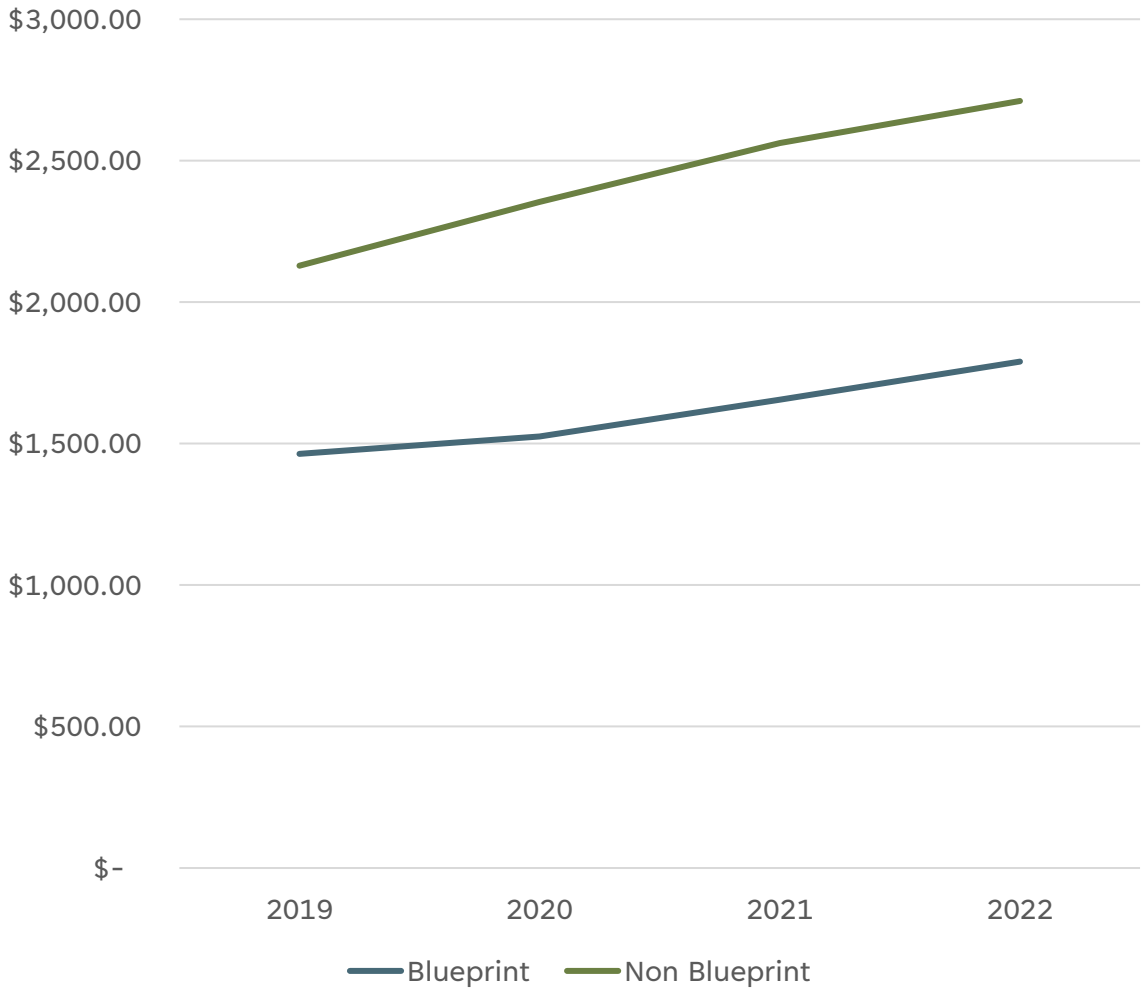
- Improve quality of care
- Ease access
- Reduce cost

BLUEPRINT-ASSOCIATED COST SAVINGS

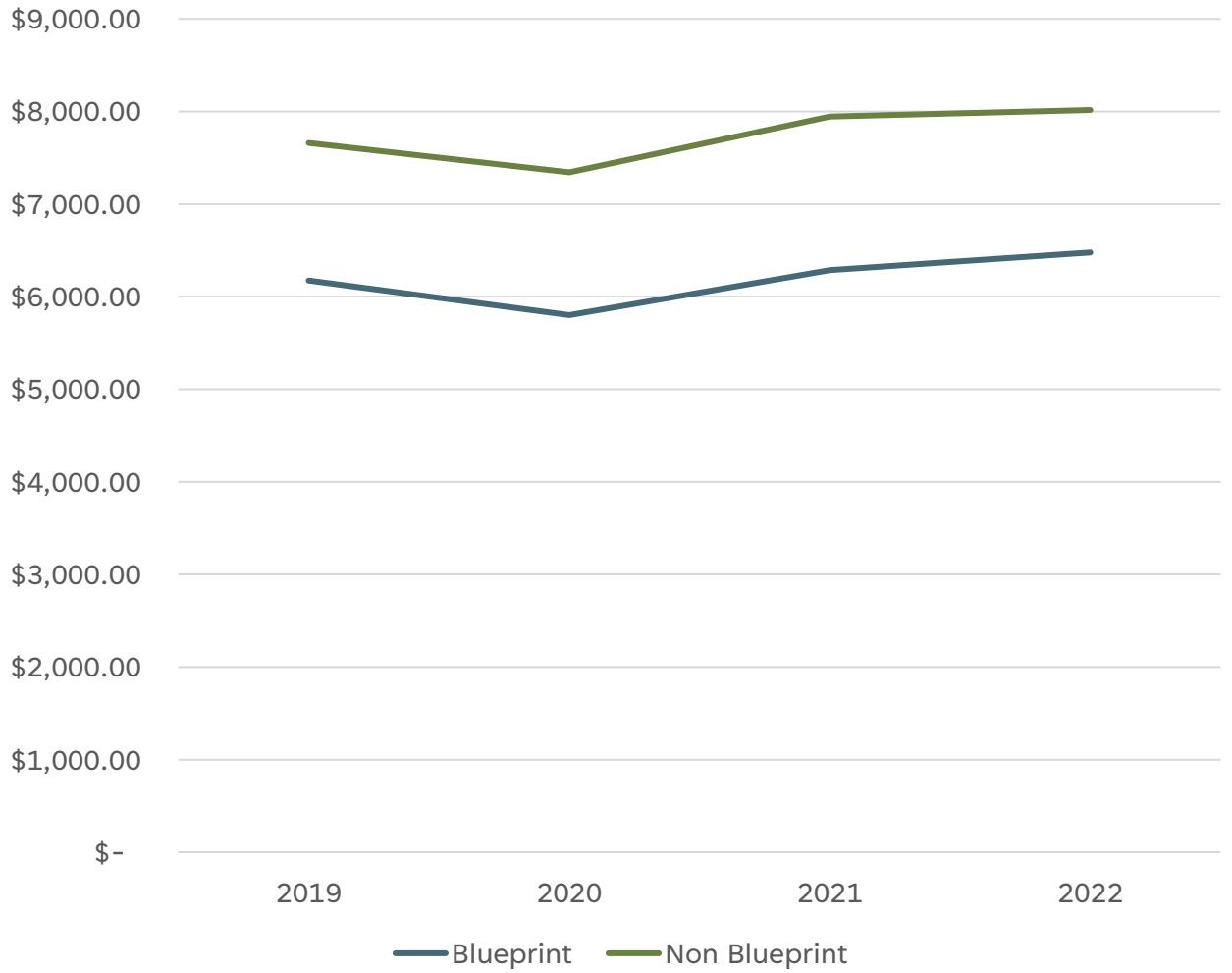
The 2017 Multi-Payer Advanced Primary Care Practice (MAPCP) demonstration report revealed significant cost savings from Blueprint for Health programming (patient-centered medical homes, community health teams, and support and services at home) across 14 quarters.

Data published by Jones et al. in 2016 identified significant cost savings associated with Blueprint participation over a 6-year period.

Pharmacy Claims Per Member



Medical Claims Per Member



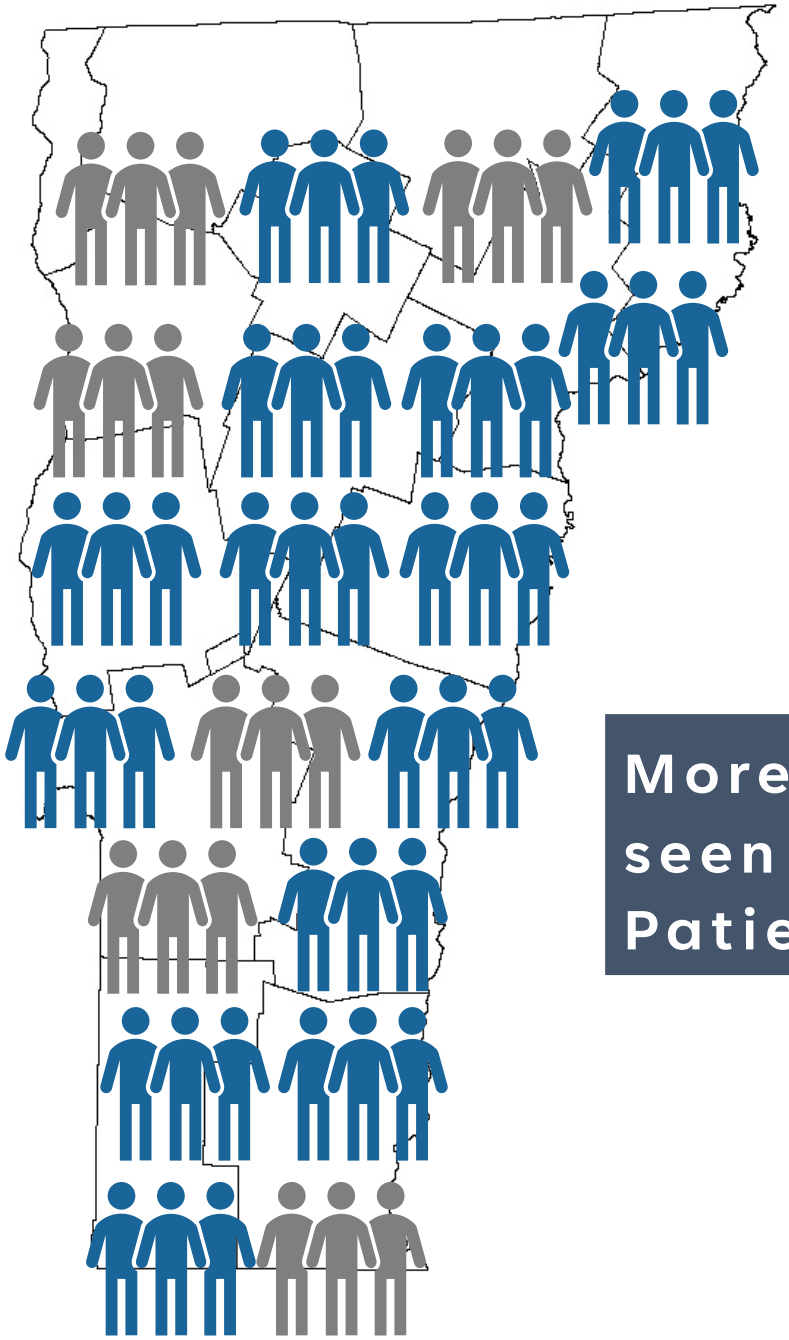
Dataset represents claims filed during these fiscal years that were reported to the VHCURES all payer claims database.

BLUEPRINT-ASSOCIATED OUTCOME IMPROVEMENTS

In a 2014 mixed methods evaluation by the Centers for Disease Control and Prevention (CDC), the community health team (CHT) model in St. Johnsbury, Vermont was associated with:

- Increased efficiency within primary care
- Improved patient wellbeing
- Increased patient adherence to treatment and attention to health

BLUEPRINT PRACTICE PATIENTS



More than 70% of Vermonters are seen in a Blueprint-supported Patient-Centered Medical Home.

HEALTH SERVICE AREAS

***BARRE:** Central Vermont Medical Center

BENNINGTON: SVMC Southern Vermont Medical Center

***BRATTLEBORO:** Brattleboro Memorial Hospital

****BURLINGTON:** University Vermont Medical Center

MIDDLEBURY: Porter Medical Center

MORRISVILLE: Lamoille Health Partners

NEWPORT: North Country Hospital

RANDOLPH: Gifford Medical

***RUTLAND:** Rutland Regional Medical Center

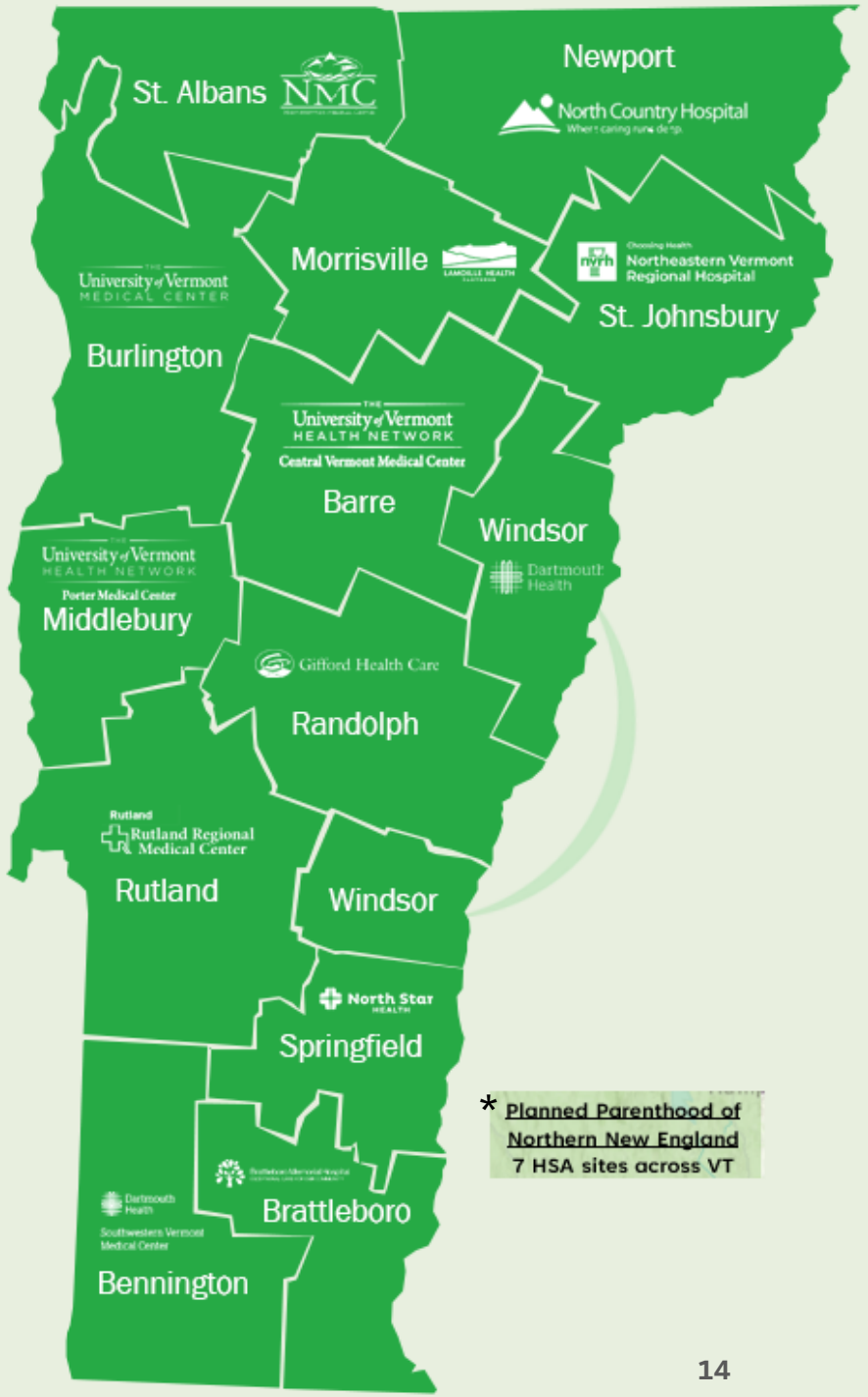
SPRINGFIELD: North Star Health

ST. ALBANS: NMC Northwestern Medical center

***ST. JOHNSBURY:** NVRH Northern Vermont Regional Hospital

***WINDSOR:** MAHHC Mt Ascutney Hospital and health Center

- will receive multi-insurer payments to support hiring of Community Health Teams
- must be Centers for Medicare and Medicaid Services (CMS) eligible providers



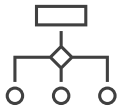
PROGRAM MANAGERS IN EACH HSA

FUNDED BY

annual grant signed for salary of a Quality Improvement Facilitator *(in some HSAs)*

REPORTS

primarily responsible for data collection, entry and completion



OVERSIGHT

administers CHT funds/staffing

COMMUNITY

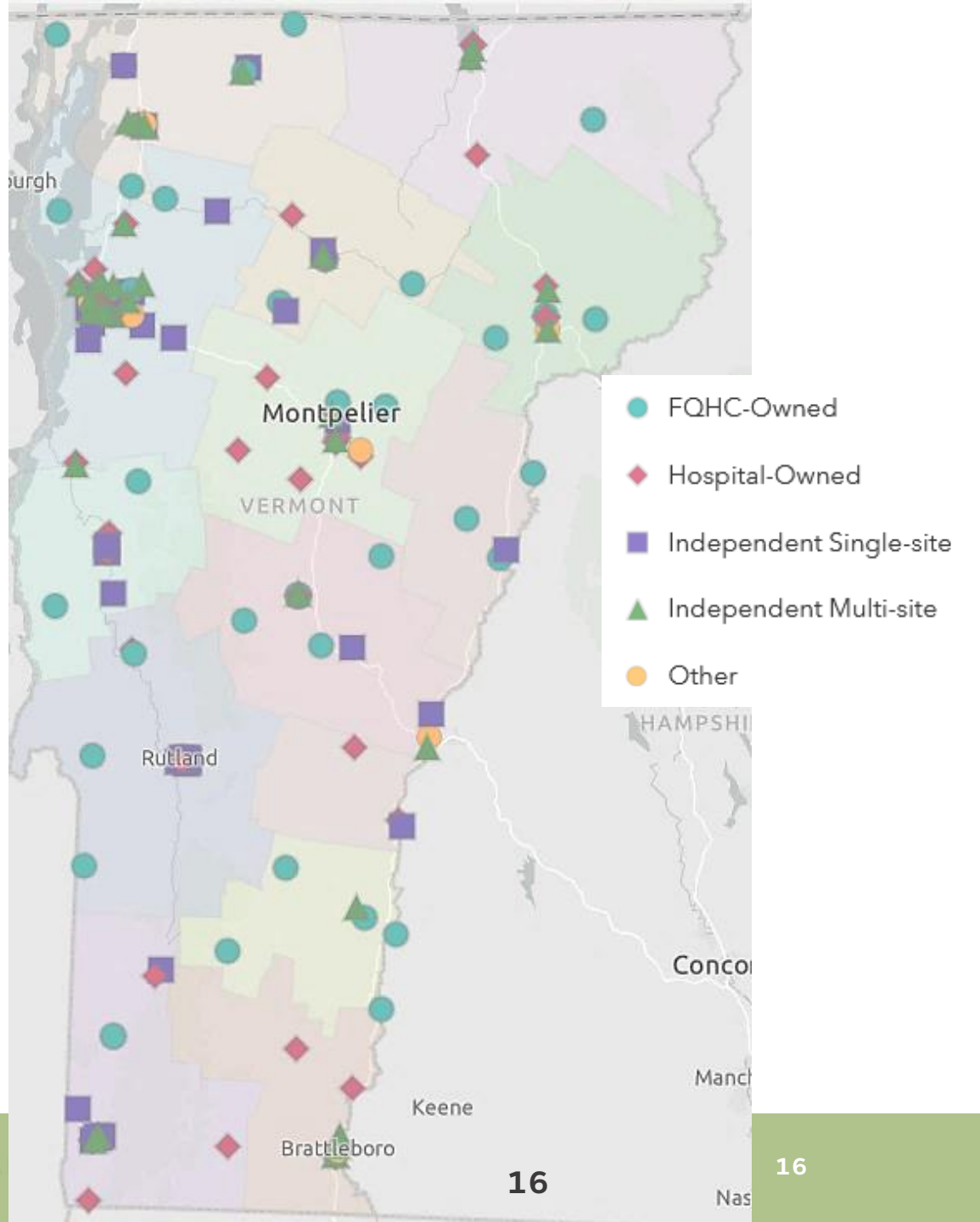
collaborates and assists staff of PCMHs within the Health Service Area

Patient-Centered Medical Homes

130 Practices/Organizations
Must achieve and sustain recognition as a PCMH from the National Committee on Quality Assurance (NCQA)
Quality Improvement Facilitation

Community Health Team

Core Community Health Team
Pregnancy Intention Initiative
Self Management
Hub & Spoke system of Opioid Use Disorder Treatment
CHT Expansion
Population data and analytics for policy makers and communities



PATIENT CENTERED MEDICAL HOMES (PCMH)

ACTIVE ENGAGEMENT

Practices/Organizations annually pay a fee and register in a system called Q-PASS

NATIONAL STANDARDS

Must achieve and sustain recognition as a PCMH from the National Committee on Quality Assurance (NCQA)

Copy of Standards: http://www.ncqa.org

"KM"	"AC"	"CM"	"CC"	"QI"
Knowing and Managing Patients	Patient Centered Access and Community	Care Management and Support	Care Coordination and Care Transition	Quality Improvement and Performance Management

QUALITY IMPROVEMENT FACILITATORS

ADOPT

Models of Care

- Patient Centered Medical Home
- Integrated Mental Health and Substance Use Care
- Community Collaboratives/Accountable Communities for Health

Best-Practices

- Population Health Management
- Team Based Care

IMPROVE

Clinical, experience, or cost priorities (identified by the practice or external entity)

SUPPORT

- Population Health and Payment Reform Efforts
- Community and Organizational Quality Priorities
- NCQA Recognition
- Continuous Quality Improvement Capacity

PATIENT CENTERED MEDICAL HOME AFFILIATION TYPE

AFFILIATION TYPE	BP PRACTICE COUNT
FQHC-Owned	48
Hospital-Owned	42
Independent Multi-Site	13
Independent Single-Site	27
Grand Total	**130**

PCMH PAYMENTS

PER MEMBER PER MONTH (PMPM)

BASE PAYMENT

$3.00	Commercial
$4.65	Medicaid
$2.15	Medicare

PAID BY COMMERCIAL AND MEDICAID

PATIENT HEALTH CARE UTILIZATION – PRACTICE

PERFORMANCE PAYMENT

UP TO $0.25

Captures the number of services and their relative weight based on resources using their Resource Use Index (RUI) score, without price variation

PAID BY COMMERCIAL AND MEDICAID

QUALITY MEASURE OUTCOMES – COMMUNITY & HSA

PERFORMANCE PAYMENT

UP TO $0.25

Measures affected by community, social, and environmental factors

- % of adolescents with an annual well-care visit (HEDIS AWC);
- % of children up to 3 years of age who have had a developmental screening (NQF 1448);
- % of individuals with hypertension in control (NQF 0018);
- % of individuals with diabetes in poor control (HgA1c > 9) (NQF 0059).

BLUEPRINT PATIENT CENTERED MEDICAL HOME
MONTHLY PAYMENTS PAID TO THE PRACTICE

PAYER	ATTRIBUTED PATIENT POPULATION PROVIDED BY PAYERS	PCMH PRACTICE BASE PAYMENT RATE (PER PATIENT PER MONTH)	PCMH PRACTICE PERFORMANCE PAYMENT RATE (PER PATIENT PER MONTH)	TOTAL PAID TO PRACTICE
Commercial Insurers CIGNA	20	$3.00	$0.32	$66.40
Commercial Insurers BCBS	400	$3.00	$0.32	$1,328.00
Commercial Insurers MVP	60	$3.00	$0.32	$199.20
Medicaid	800	$4.65	$0.32	$3,976.00
Medicare	1020	$2.15	$0.00	$2,091.00
Monthly Total	2300			$7,660.60

COMMUNITY HEALTH TEAM

SUPPORT PRIMARY CARE PROVIDERS

- identifying root causes of health problems
- including mental health
- screening for social drivers of health
- team based care

CONNECT PATIENTS

- effective interventions
- support to manage chronic conditions
- provide additional opportunities to support improved well-being by engaging in team-based care

FUNDED COMMUNITY HEALTH TEAM

HEALTH EDUCATION

MENTAL HEALTH AND SUBSTANCE PATIENT CARE

FAMILY SPECIALIST

CARE MANAGERS/ COORDINATORS

PANEL MANAGERS

NUTRITION SUPPORT

COMMUNITY HEALTH WORKERS

COMMUNITY IS A WHOLE HEALTH TEAM

FOOD SHELF

HOME HEALTH

PEERS

HOUSING

DESIGNATED MENTAL HEALTH AGENCIES

VERMONT CHRONIC CARE INITIATIVE

AND MANY MORE...

HEALTH SERVICE AREAS RECEIVE FUNDS FROM INSURERS FOR STAFFING A

COMMUNITY HEALTH TEAM

CHT Capacity Investment aids Vermonters

- greater access
- multi-disciplinary
- medical and social services

PER MEMBER PER MONTH

$2.77	Commercial WHI: $0.00 MOUD: $0.00
$2.77	Medicaid
$2.68	Medicare

CHT STAFFING MODELS

- Money for hiring staff sent directly to practices through Administrative Entity

OR

- or contract with another entity such as local Designated Agency

CHT PAYMENTS:

PRIMARY CHT STAFF

MOUD CHT STAFF

WHI CHT STAFF

CHT PAYMENT STRUCTURE

BLUEPRINT CORE COMMUNITY HEALTH TEAM QUARTERLY PAYMENTS MADE TO THE ADMINISTRATIVE ENTITY

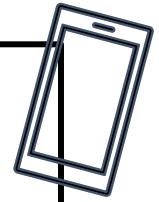
PAYER	ATTRIBUTED PATIENT POPULATION PROVIDED BY PAYERS	COMMUNITY HEALTH TEAM STAFFING PAYMENT RATE (PER PATIENT PER MONTH)	TOTAL PAID TO ADMIN ENTITY
Commercial Insurers CIGNA	65	$2.77	$544.00
Commercial Insurers BCBS	4064	$2.77	$33,774.92
Commercial Insurers MVP	689	$2.77	$5,725.74
Medicaid	4,340	$2.77	$36,066.36
Medicare	3,708	$2.68 (+$0.31 to risk-bearing providers in the Medicare ACO)	$30,954.00
Monthly Total	**12,866**		**$107,065.02**

SUPPORTING PREGNANCY INTENTION AND HEALTHY FAMILIES

COMPREHENSIVE FAMILY PLANNING COUNSELING

- Increased access to preconception counseling has been shown to improve maternal and infant outcomes. ***One Key Question***
- Increased access to contraceptive counseling has been shown to be an effective intervention for reducing the rate of unintended pregnancies
- Same day access to long-acting reversible contraceptives (LARC) and/or moderate to most effective contraception
- Funded only by Medicaid currently

PSYCHOSOCIAL SCREENING, INTERVENTION, AND NAVIGATION TO SERVICES

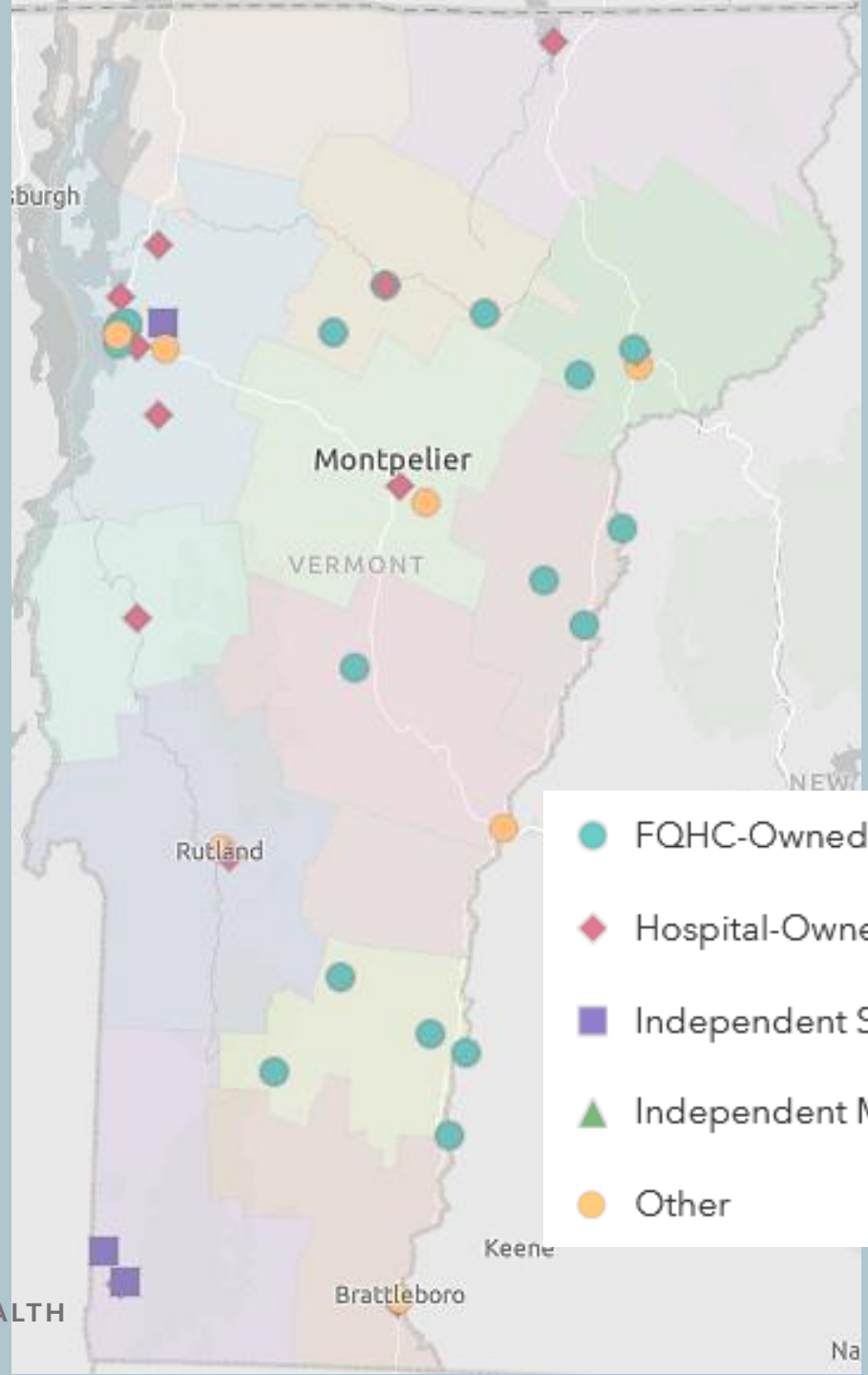


- Enhanced screening that includes ***Social Drivers of Health***
- Brief intervention and referral/navigation to treatment and services
- Care coordination agreements with Primary Care/Community Partners

PREGNANCY INTENTION INITIATIVE SITES FUNDING

PAYMENT:

- Based on number of Medicaid patients ages 15-44 who had a qualifying claim
- Funding to support hiring a licensed counselor at Specialty Practices
- Utilize current CHT at PCMH
- PMPM $1.25 to support administering the program



SELF-MANAGEMENT

SUPPORT ACROSS THE STATE

- provided by grant agreements between the Department of Health and administrative entities
- takes advantage of the additional funding and content expertise that exists within Health Promotion and Disease Prevention
- pairs it with the Blueprint's influence at the local level

MYHEALTHYVT.ORG

FREE WORKSHOPS

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

HUB AND SPOKE PROGRAM

EST. 2013

HUBS

9 PROGRAM SITES

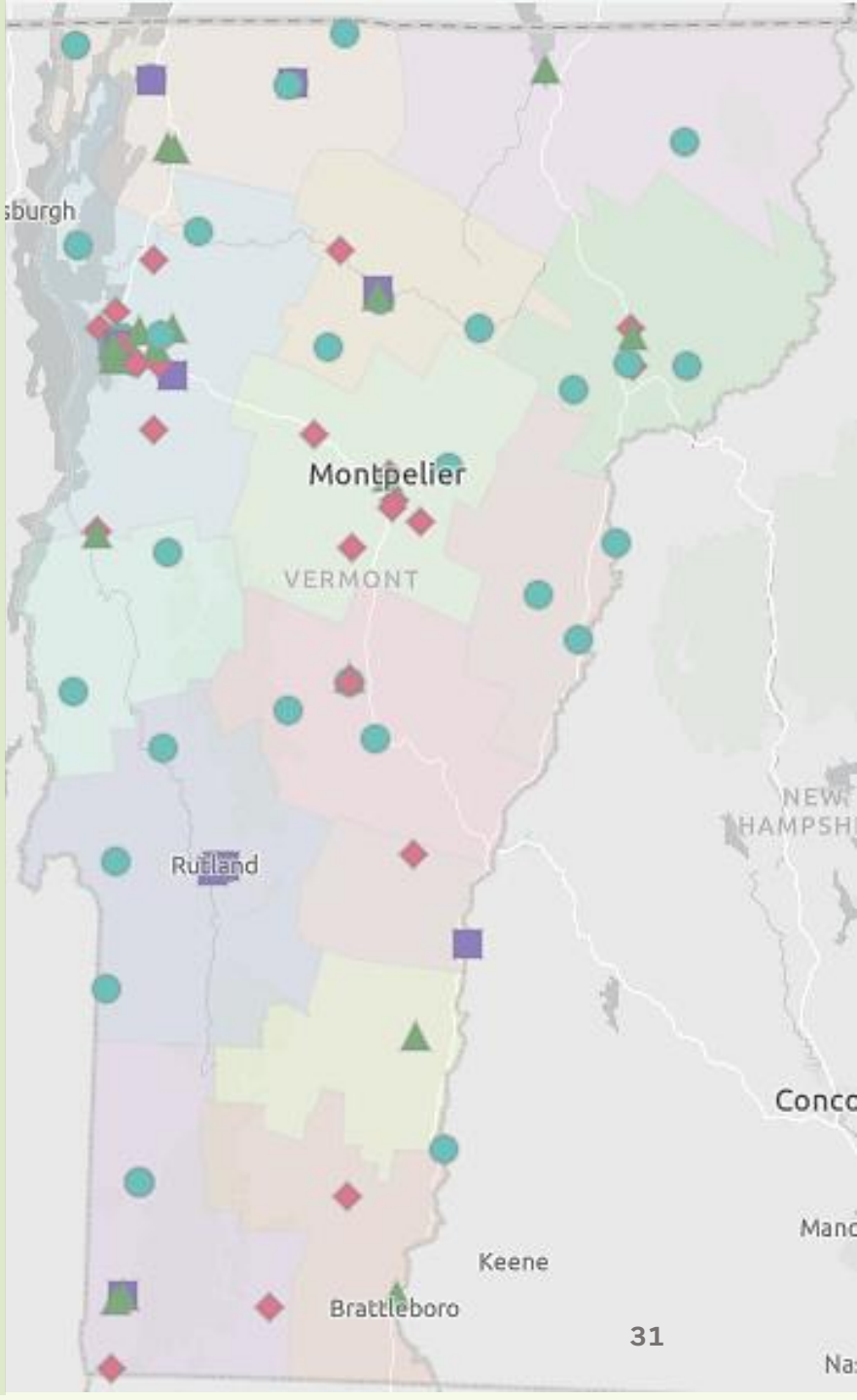
- Enhanced OTPs (Opioid Treatment Programs)
- Dispense Buprenorphine & Vivitrol addition to Methadone
- Augment staffing for health home services (care managers, counselors, nurses, and psychiatry)
- Monthly bundled rate

SPOKES

91 PROGRAM SITES

- Enhanced OBOTs (Office Based Opioid Treatment)
- 1 FTE RN & 1 FTE Licensed Addictions/Mental Health Counselor for 100 Medicaid Members provide health home services. (Claims based on Buprenorphine/Vivitrol Medicaid prescriptions)
- Hired and deployed as part of Blueprint CHT though the administrative entity

- Patients move between Hubs and Spokes based on their clinical needs
- Hubs and Spokes provide mutual support in conjunction with PCP
- RAM (Rapid Access to Medication)



ACT 167

"On or before January 15, 2023, the Director of Health Care Reform in the Agency of Human Services shall recommend ... the amounts by which health insurers and Vermont Medicaid should ***increase the amount of the per-person, per month payments*** *they make toward the shared costs of operating the* ***Blueprint for Health community health teams*** *... in furtherance of the goal of providing additional resources necessary... to* ***sustain access*** *to primary care services in Vermont.*

The Agency shall also provide an ***estimate of the State funding*** *that would be needed to support the increase for Medicaid, both with and without federal financial participation."*

S 285, 2021 - 2022

"...for a two-year pilot to expand the Blueprint for Health... program. Funds shall be used to expand the substances covered by the program, include mental health and pediatric screenings, and make strategic investments with community partners;"

Act No. 78, 2023

NEED FOR COMMUNITY HEALTH TEAM (CHT) EXPANSION

- Increase the number of Community Health Workers, counselors, and social workers
- Balance existing workload with more support for mental health and substance use concerns
- Create consistent funding for evidence-based program, DULCE

1 IN 5 Americans experience mental illness

Each Year:

- **1 IN 20** Americans experience serious mental illness
- **5% TO 15%** of adolescents and adults experience a substance use disorder

Vermont has the highest rate of suicide death in New England, and the 18th in the nation as of 2020.

National Action Alliance for Suicide Prevention

Statistics from National Alliance on Mental Illness (NAMI)*

COMMUNITY HEALTH TEAM EXPANSION WORKGROUP DEVELOPMENT

YEAR 1 GOALS

PROGRAM DESIGN
Screening
Referral workflow

- Social Drivers of Health
- Childhood developmental screenings
- Mental Health/Substance use
- Housing
- Inter-partner violence

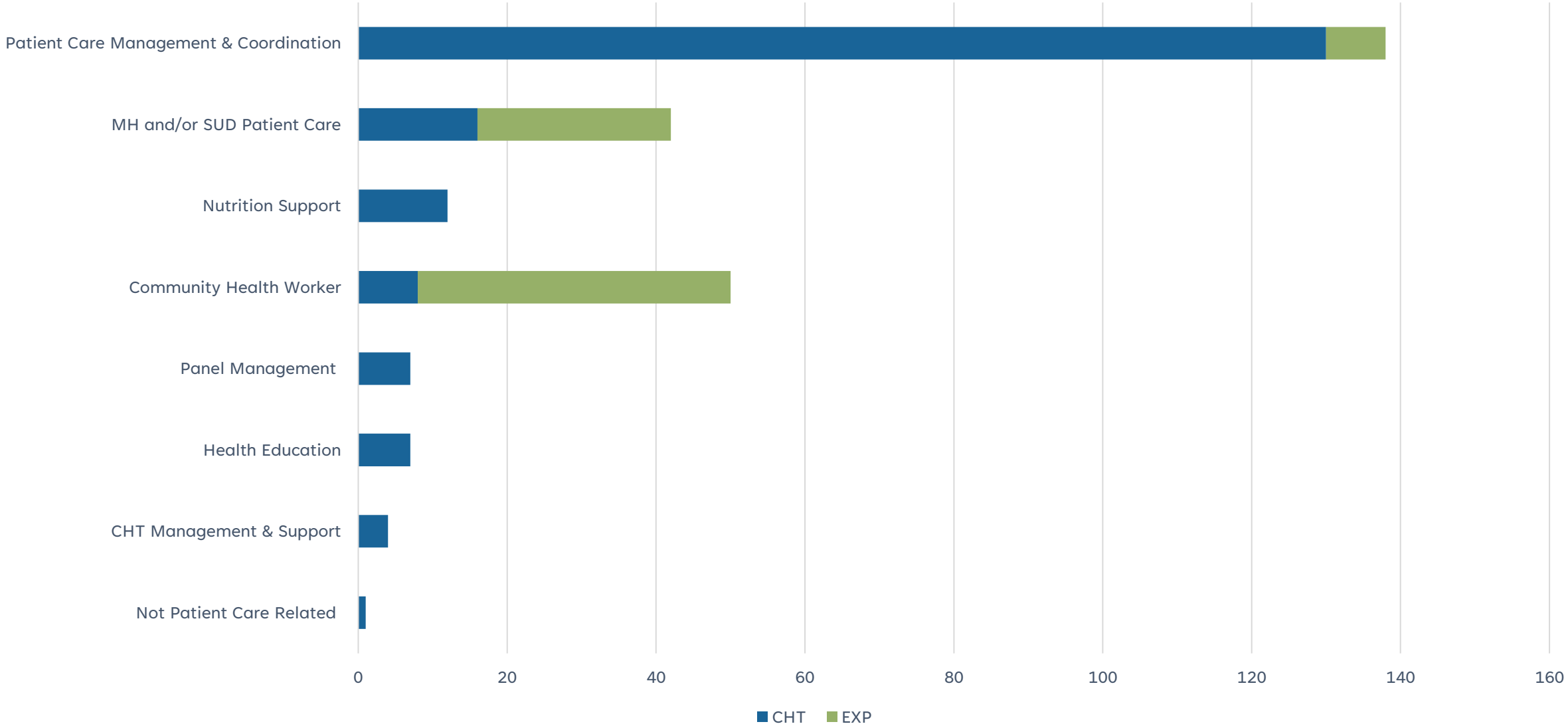
MEASUREMENT & EVALUATION
Outcome measures
Data collection processes

- Year 1 chart review
- Staffing increase

PAYMENT
Review of current funding mechanisms
Evolution of new payment methods

- Payments to enhance staffing
- Staffing recommendation guide
- Medicaid investment only but staff serves all
- Attestation to goals of program

Community Health Team Staff Count, Before & After Expansion
July 2024



CHT CHART REVIEW SNAPSHOT

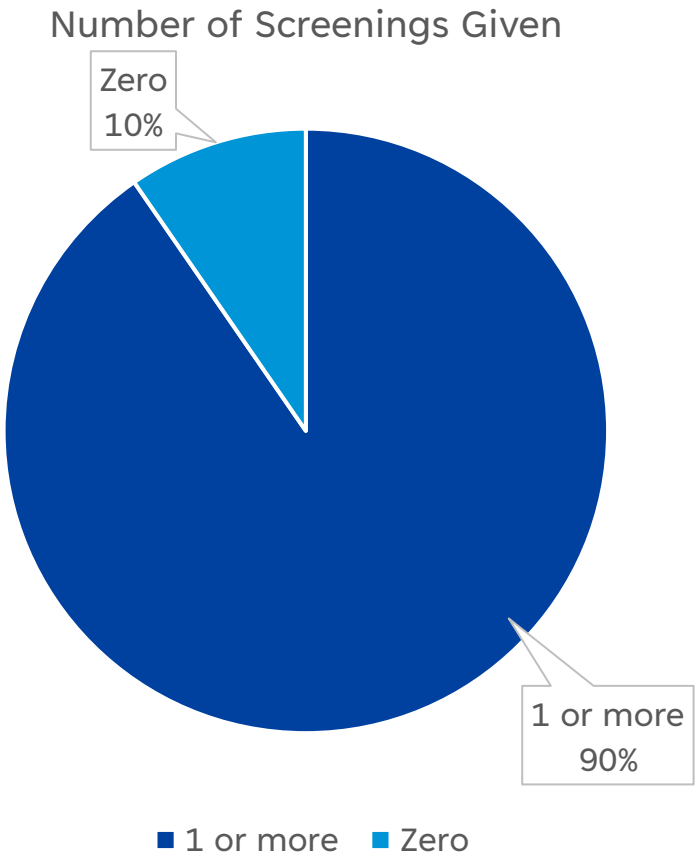
The CHT Expansion Pilot included an opportunity for a detailed chart review by Blueprint Quality Improvement Facilitators.

QI Facilitators conducted a chart review at Blueprint practices in October and November of 2023.

The work reviewed **530 charts** for CHT encounters during the previous quarter and resulted in 520 usable data entries.

This chart review provides an opportunity **to understand and analyze** the work CHTs are doing across the state.

CHT SCREENINGS GIVEN



Screening Type	% Screened
Mental Health	78.7%
Substance Use - Other	78.7%
Substance Use - Alcohol	62.6%
Food Security	50.4%
Housing Insecurity	46.2%
Substance Use - Opioids	42.6%
Safety (Interpersonal, IPV, Abuse...)	21.5%
Transportation	20.9%
Suicide	20.4%
Financial	16.2%

COMMUNITY HEALTH TEAM EXPANSION PILOT
YEAR 2

PROGRAM DESIGN
Screening
Referral workflow

- Social Drivers of Health
- Developmental Screenings
- Integrating DULCE in practices teams
- Attestation
- Quality Improvement

MEASUREMENT & EVALUATION
Outcome measures
Data collection processes

- Chart review
- Interpret Screening and report out

Qualitative

- Patient surveys and interviews
- Provider Survey/Interviews
- CHT surveys

Quantitative analyses will be complete in 2025

PAYMENT
Review of current funding mechanisms
Evolution of new payment methods

- Payments to enhance staffing
- Staffing recommendation guide
- Medicaid investment only but staff serves all
- Updated Attestation to commitment of goals.

EDUCATION AND TRAINING

BLUEPRINT FOR HEALTH SUPPORTS PROGRESS AND DEVELOPMENT IN HEALTH AND WELLNESS BY OFFERING

- **Lunch and Learn** – listed on website
  (Example: Dementia, RETAIN, Dept of Mental Health 988 and many more)

- **CARE series** –Collaboration to advance mental health treatment
  and substance use disorder recovery

- **CHT Trainings** –
  Pediatric model in conjunction with Family Child Health
  Structural Competency and cultural Humility to address
  disparities and inequity
  Pride Center Webinars
  Motivational Interviewing
  Community Health Worker and CHW Supervisor

RESOURCES

Blueprint for Health Manual and Implementation
https://blueprintforhealth.vermont.gov/implementation-materials

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

Expansion Attestation
https://blueprintforhealth.vermont.gov/sites/bfh/files/doc_library/BPCHT_Expansion_Attestation_Fillable%20-%20Julie%20and%20Mara.pdf

Expansion Proposal Report and Workgroups
https://blueprintforhealth.vermont.gov/expansion-proposal-workgroups

RESEARCH AND EVALUATION

Community Profiles
https://blueprintforhealth.vermont.gov/community-health-profiles

PII Evaluation
https://blueprintforhealth.vermont.gov/womens-health-initiative-profiles

H&S/MAT Evaluation/Profiles
https://blueprintforhealth.vermont.gov/hub-and-spoke-profiles ;
https://blueprintforhealth.vermont.gov/reports-and-articles/journal-articles

Annual Report
https://blueprintforhealth.vermont.gov/annual-reports

QUESTIONS?

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THANK YOU