Blueprint for Health Community Health Team (CHT) Expansion Pilot: Year 1

Vermont is experiencing increased deaths from drug overdose and suicide and concerning levels and acuity of mental health and substance use disorders. In addition, there is a need to broaden screening for social determinants of health and address mental and physical health-related social needs of Vermonters of all ages. The objective of this project is to ensure that screening, brief intervention, and navigation to services occurs across the entire population served by primary care practices in Vermont that participate in the Blueprint for Health (most primary care practices in the state).

Eligible Practices

Blueprint Patient-Centered Medical Homes (PCMH) with at least 50 attributed Medicaid members are eligible to receive additional support. Blueprint PCMHs with between 50 and 250 attributed Medicaid members will receive this support through a centralized resource in the Health Service Area (HSA). Practices with at least 250 attributed Medicaid members are eligible to receive support in the form of embedded staff at levels commensurate with their Medicaid member attribution; these staffers may be hired by the practices utilizing pass-through funding or employed by the Blueprint Administrative Entities in their health service areas.

Practice Requirements

Blueprint Program Managers will meet with each practice to review eligibility for participation in the CHT Expansion Pilot. Practices will review an attestation document containing information regarding the requirements of participation. Each practice that decides to participate in the Expansion Pilot will sign the attestation and return it to their Blueprint Program Manager for signature. Blueprint Program Managers will send all signed attestations to the Blueprint central office for approval.

Provider Requirements

Delivering effective integrated care across all ages may require practices to make shifts in their culture, workflows, and/or clinical operations. Providers are asked to engage in team-based care that includes increasing mental health and substance use screenings and support for patients and families within the practice. Providers will also engage with quality improvement teams and training offered as part of the Pilot. Practices will be expected to make any necessary shifts in culture, workflows, and/or clinical operations with support from Quality Improvement Facilitators, state-level Blueprint staff, and training offered by Blueprint.

Organized and streamlined procedures that place primary care providers, CHT providers, outside referral specialist organization (e.g., designated agencies, parent child centers, support group leaders), patients, and their supporters in frequent communication enhance whole-person, team-based, integrated care. The focus of the CHT Pilot Expansion is on enhancing access to this level of integrated care for patients in all life stages.

Screenings to Identify Mental Health, Substance Use, and Health-Related Social Needs

This information is included in the practice attestation document (attached).

Payment Disbursement

Administrative Entities received their first payments from Medicaid in August 2023, and will receive payments monthly for the duration of the Pilot. It is the responsibility of the Administrative Entities, in consultation with participating practices, to determine whether to hire staff directly or pass through dollars to practices for the hiring of staff.

Payment Amount Determinations
Payment amounts for each HSA are determined by the number of Medicaid members attributed to each practice within the HSA based on the Blueprint attribution methodology. Attribution levels will be held constant for the first year of the Pilot and reassessed at the end of the first year. See the Vermont Blueprint for Health Manual for a detailed table of amounts and methodology.

Allowable Uses of Funding
The CHT Expansion Pilot funding shall be used to embed a Community Health Worker, Family Specialist, master's prepared licensed or unlicensed Mental Health Counselor, Social Worker, or Psychologist as a member of the primary care team. The Administrative Entity may hire directly, pass through dollars to a practice to hire or contract with an outside referral specialist organization. Funding may also be used to support the development of the same types of centralized staffing to serve smaller practices. Requests for alterations in staffing type must be addressed to the Blueprint Executive Director by the Blueprint Program Manager and accompanied by justification. Such requests are subject to approval by the Blueprint Executive Director.

The Administrative Entity may use up to 1 month of funding from the first year of support (8.3% of funding from the first year) for administrative costs related to the CHT Expansion Pilot. Such costs may include the cost of posting positions, interviewing, electronic health record enhancements, and creating memoranda of understanding (MOUs) or contracts.

Embedded vs. Centralized Staff
Embedded CHT staff support an integrated model of mental health and substance use disorder care when primary care and mental health, substance use, or social services specialists are co-located within the same clinic space and share the overall care and treatment plan of the patient.

Centralized CHT staff support a coordinated model of integrated care, where primary care and mental health, substance use, or social need specialists are housed in separate locations and identification of patient needs and communication is primarily provider driven. Patients and providers must be able to reach centralized CHT staff through telehealth and centralized CHT staff shall have regular availability to support practitioners and patients.

Staffing at Multi-site Practice Organizations
Staff models to determine payment and FTE counts occur at the practice site (rather than multi-site practice organization) level, with the intent of supporting as many practice sites to employ an embedded resource as possible. The CHT staff member ideally is always available to the practice site's providers and patients during the workday, whether that involves a warm hand off to transition care or quick consultations. Every Health Service Area and multi-site practice organization can discuss resource needs and creative solutions to staffing positions in each practice site.

Expected Interventions
Community Health Teams will provide evidence-based mental health and substance use treatments appropriate to the primary care setting. They will also support screenings for mental health, substance use, family, and social needs, provide education, and offer self-management support and strategies.

For individuals with complex needs, CHT staff may play a greater role as a care coordinator and assist with managing transitions of care, co-management of care, care consultations, team-based care, and care conferences.

Reporting Data to Blueprint
Reporting requirement information is located on the attestation document. The evaluation of the first year of the Pilot will focus primarily on understanding Pilot adoption and implementation. Clinical processes and outcomes will primarily be analyzed via Quality Improvement Facilitator-led chart reviews at this stage.

Medicaid Attribution Discrepancies
If Blueprint Program Managers are concerned about any discrepancies between the CHT Expansion Pilot payment methodology and other methods used to calculate practice/organization Medicaid caseload, they may contact the Blueprint Payment Administrator, Jennifer Herwood at Jennifer.Herwood@vermont.gov.

Program Manger Flexibility in Resource Allocation
If anticipated staffing needs vary from recommended staffing levels for the practice provided by the Blueprint for Health central office, Program Managers should contact the Executive Director to discuss potential solutions.

Current Positions and Expansion Funding
The intent of this Pilot is to expand CHT resources; as a result, funding shall be used to increase CHT staffing resources available to practices to address mental health, substance use, social determinants, and family specialist needs for all patients. If a practice has existing mental health and substance use disorder treatment services, practices and program managers should assess what unmet mental health, substance use, and social or family needs exist in the practice population to determine if other resources may be appropriate for the practice. It may be that the addition of another resource, such as a Community Health Worker, would allow existing mental health and substance use providers to work to the top of their license and address unmet needs. As a reminder, services provided by CHTs are not billable.

Practices should contact their local Program Manager with any questions or considerations specific to the practice. Program Managers may discuss individual practice questions or considerations with the Executive Director.

Time-bounded Funding
The Blueprint for Health has advocated strongly with the Vermont Legislature for two years of funding to evaluate the efficacy of embedding CHT staff to address these needs in primary care practices, and the Legislature was responsive to that request. If the CHT Expansion Pilot is successful, it will serve as the foundation for making these funds permanently available as part of the larger CHT.

Funding Source
This Pilot is being funded using Global Commitment to Health (Global Commitment) funds. Global Commitment is the name of the agreement between the State of Vermont and the Centers for Medicare and Medicaid Services (CMS) that is used to administer the majority of Vermont's Medicaid program. It is what is known as a Section 1115 Demonstration (often referred to as a "waiver") that waives certain provisions of Medicaid law to give states flexibility and encourage

state innovation in designing and improving state Medicaid programs, while remaining budget neutral to the Federal Government. These funds are not considered a grant.

Working with Existing Blueprint Staff
Added CHT staff will work closely with the existing teams in the practices. The Blueprint Quality Improvement Facilitators can engage in the development of new and revised workflows to incorporate additional staff.

Each practice may consider creating a new position, adding to an existing position, or discussing other opportunities for staffing with their Blueprint Program Manager.

Vacant Positions
Vermont is currently contending with health care workforce shortages. There are long-standing vacancies that various communities have struggled to fill. The Agency of Human Services Health Care Reform team has responsibility related to the Health Care Workforce Development Strategic Plan to address some of the system and long-term changes required.

The Blueprint for Health recommends tapping into known effective strategies and lessons learned across the nation for recruiting and retaining this workforce, which may include:

- Partnering with the local Designated Agency, Parent Child Center or neighboring Health Service Area(s),
- Exploring opportunities associated with telehealth,
- Investing in training programs and career pathways, and
- Exploring licensing support and recruitment strategies.

Program Managers should remain in close communication with the Executive Director about any ongoing staffing vacancies.

Integration with and Support for Developmental Understanding and Legal Collaboration for Everyone (DULCE) Program
This Pilot provides two years of support for the DULCE program and Family Specialist role embedded in 6 Dulce sites. These sites are also eligible for additional expanded CHT staff based on practice attribution. Administrative Entities for six DULCE sites will receive funding for their Family Specialist for two years; this funding is in addition to the amount of CHT staffing resource funding the HSA receives for the Expansion Pilot.

Vermont Department of Health and Blueprint central office staff will work directly with all HSAs to support continued development and implementation of a pediatric model that reflects Vermont's learning from the DULCE program. Pediatric practices without DULCE will engage in a pediatric model that includes elements modeled after DULCE's nine domains: Employment Security, Food Security, Intimate Partner Violence (IPV), Financial Supports, Transportation, Mental Health/Caregiver Depression, Housing Stability, Health & Safety, and Utilities. These elements are expected to be incorporated into Family Specialist positions with CHT Expansion staff. This pediatric model will not use the DULCE name due to specific requirements associated with the program; however, DULCE-like universal screening and support across all pediatric practices is an important goal of the CHT Expansion Pilot, as well as connection to existing systems of care outside of the health care system. DULCE required screenings do not currently require a specific screener to be

used for any domain. Quality improvement specialists will collaborate with providers to incorporate screenings, implement interventions, create referral pathways, and support this model in pediatric and family practices throughout Vermont.

Tracking CHT Expansion Pilot Funding

CHT Expansion Pilot funding should be tracked separately from other funding sources. Additional funding questions should be addressed to the Executive Director.

Non-participation in Blueprint Expansion Pilot

If a practice does not attest, the Blueprint strongly encourages Program Managers to propose alternative means of utilizing the funds to meet the mental health and substance use needs of the community in alignment with the goals of the Expansion Pilot. Proposals shall be presented to the Blueprint Executive Director for approval. If a proposal is not made and approved for use of unspent funds, the Administrative Entity will remit the unspent FTE funds to the State and future payments will be adjusted accordingly.

Community Health Team Expansion
July 2023-June 2024 Practice Attestation

I attest that [insert Practice Name] is a Vermont Blueprint for Health Patient-Centered Medical Home (PCMH).
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 primary care practices that are patient centered medical homes.

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.
- Engage with Quality Improvement Facilitator to implement the pilot goals and strategies, conduct continuous quality improvement activities and evaluate pilot processes and outcomes. 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. 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 as part of the evaluation process.

Staff types: The Administrative entity program manager will engage with all PCMH 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, and staffing cutoffs adjusted if necessary.

- Utilize screening for mental health, substance use, and social determinant of health needs for individuals and families.

Social Determinants of Health (SDOH) screening

- 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 recommends the use of screening tools for the following SDOH domains: food security and housing instability, according to evidence-based guidelines that are documented in the electronic health record narrative. Specifically, the recommendations for defined age groups are as follows:

Birth to age 11

Social Determinants of Health factors of the family system are reviewed via screening tool or other means and are recorded in the electronic health record narrative.

Standardized tool for periodic **developmental screening** for newborns through 30 months

Bright Futures Periodicity Scale is followed and documented including a maternal depression screen **Edinburgh Postnatal Depression Scale** (EPDS) is administered at 1, 2, 4, and 6 months and as indicated for mothers and/or caregivers and their partners

Ages 12-17

Social Determinants of Health factors are reviewed via screening tool or other means and are recorded in the electronic health record narrative.

Substance Use Screener CRAFFT (Car, Relax, Alone, Forget, Family/Friends/Trouble) is administered according to evidence-based guidelines. If you choose to use other evidence-based tools in the first year of pilot implementation, the tool(s) must be indicated here: _____.

Tobacco Screening is administered per evidence-based guidelines.

Mental Health Screening using the Patient Health Questionnaire Modified for Adolescents (PHQ-9A) is conducted per evidence-based guidelines.

Ages 18 and up

Social Determinants of Health factors are reviewed via screening tool or other means and are recorded in the electronic health record narrative.

Substance Use Screeners Alcohol Use Disorder Test (AUDIT) and Drug Abuse Screening Test (DAST 10) are administered according to evidence-based guidelines. If you choose to use other tools to screen for alcohol and substance use in year one (1), the tools must be indicated here: _____.

Tobacco Screening is administered per evidence-based guidelines.

Mental Health screening is administered using the PHQ 2(Patient Health Questionnaire) according to evidence-based guidelines

The Blueprint strongly suggests using the PHQ 9 and/or Columbia Suicide Severity Rating Scale (CSSR) screening to address suicide risk.

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

Education Participation

The practice will 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.

Evaluation/Measurement Participation – Year One*

The practice agrees to report the following information noted below to the Blueprint Program Manager. The practice agrees to allow access to the quality improvement facilitators and pilot evaluators to collect data in the following areas for evaluation purposes.

- The Blueprint will request these measures be sent by November 15, 2023.
- Practices will then submit to the Blueprint Program Manager, prior to the fifteenth (15th) day of the first month of each calendar quarter ongoing (April, July, and October).

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. Descriptive Episodes of CHT Care (chart review, per practice # TBD) This will be completed by Quality improvement facilitators in October of 2023.

4. Status of practice adoption and implementation via survey sent from Blueprint Central Office and completed by practices.
5. Status of contracting for QI Facilitators, Trainers, and Evaluators will be reported by central office.
6. Trainings offered/number of staff and staff types attending will be collected by Central office.
7. Practice Engagement in Quality Improvement Process will be added to expectations of the quarterly Quality Improvement Facilitators report.

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 receive pass through dollars to allow practices to hire embedded staff as described in the Blueprint manual in collaboration with BP HSA 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

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 Averiel.Hossley@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)

Screening Tools:

1. CRAFFT
2. Edinburgh Postnatal Depression Scale (EDPS)
3. PHQ-9 modified for Adolescents (PHQ-A)
4. PHQ-2 and PHQ-9
5. Alcohol Use Disorders Identification Test (AUDIT)
6. Columbia Suicide Severity Rating Scale (CSSR)

Other Resources:

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