BLUEPRINT FOR HEALTH

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AGENCY OF HUMAN SERVICES

The AHS Central Office, or
"The Secretary's Office"

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.

BLUEPRINT FOR HEALTH CENTRAL OFFICE STAFF

WATERBURY, VERMONT

DR. JOHN SAROYAN
Executive Director

JULIE PARKER
Assistant Director

MARA KRAUSE DONOHUE
Assistant Director

AVERIEL HOSSLEY
Project Administrator

ERIN JUST
Quality Improvement Coordinator

DR. ADDIE ARMSTRONG
Data Analytics and Info Administrator

CALEB DENTON
Data Analytics and Info Administrator

JENNIFER HERWOOD
Payment Operations Administrator

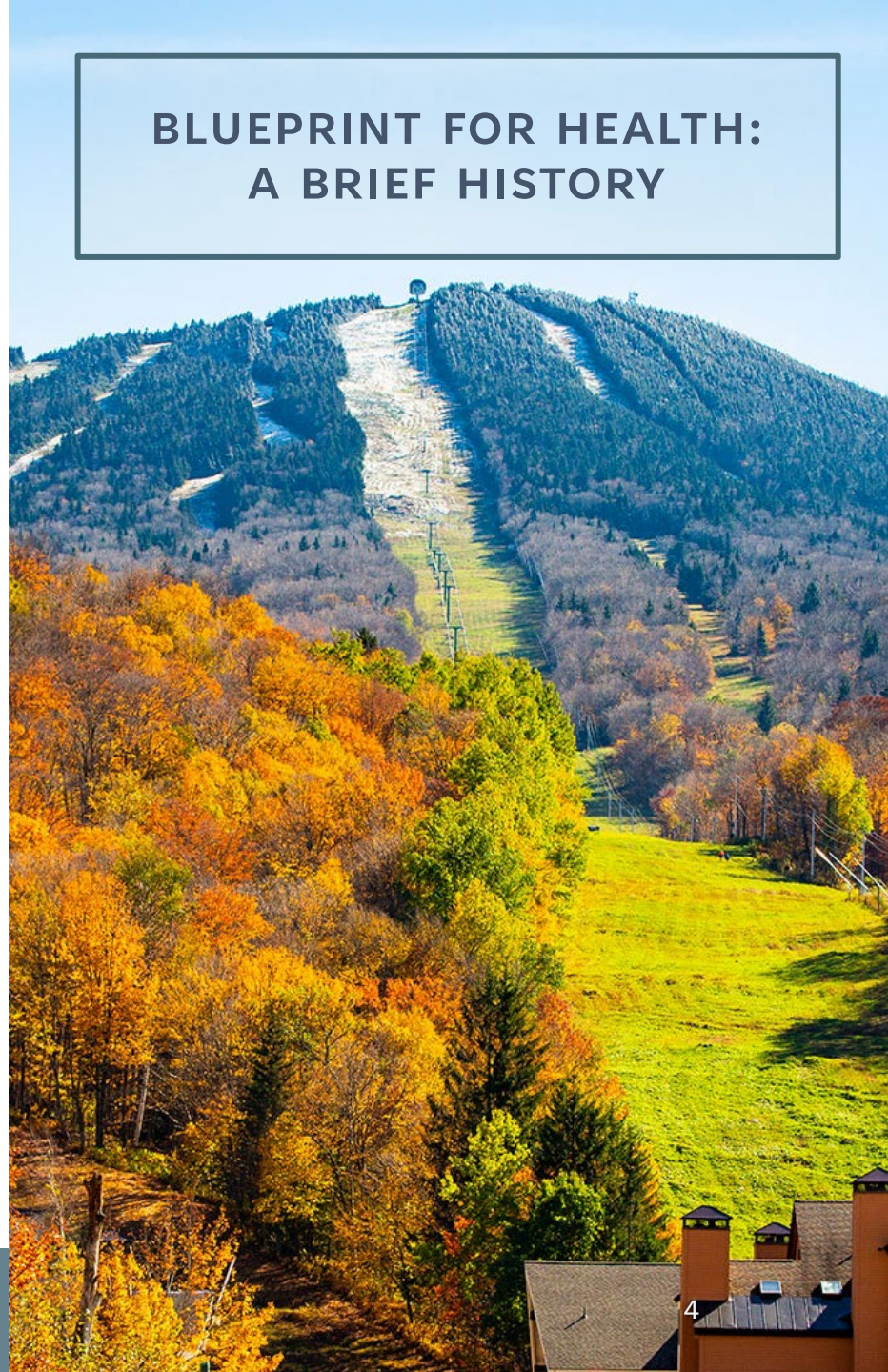
NICHOLE BACHAND
Administrative Assistant

DR. MONIQUE THOMPSON
Specialty QI Facilitator

DR. MEREDITH MILLIGAN
Physician Clinical Consultant

BLUEPRINT FOR HEALTH: A BRIEF HISTORY

2006	Blueprint for Health codified into Vermont statute
2007	ACT 71 establishes Medical Home and Community Health Teams
2008	First pilot site: St. Johnsbury HSA
2010	Act 128 shifts the Blueprint from a pilot to a statewide program
2011	Vermont is one of the eight states selected for CMS' MultiPayer Advanced Primary Care Practice Demonstration
2013	Hub and Spoke program for Opioid Treatment and Office Based Opioid Treatment
2017	Pregnancy Intention Initiative (PII), formerly Women's Health Initiative (WHI)
2022	Act 167 Requires recommendation on the amount to increase commercial insurer and Medicaid Contributions to Community Health Teams and Quality Improvement Facilitation
2023	Legislature approved the budget to include funding for the Blueprint for Health Community Health Team Expansion Pilot Program

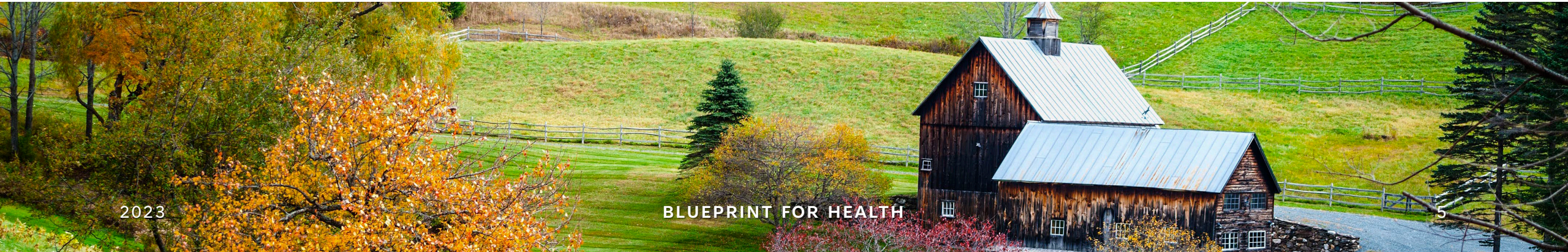


ACT 128

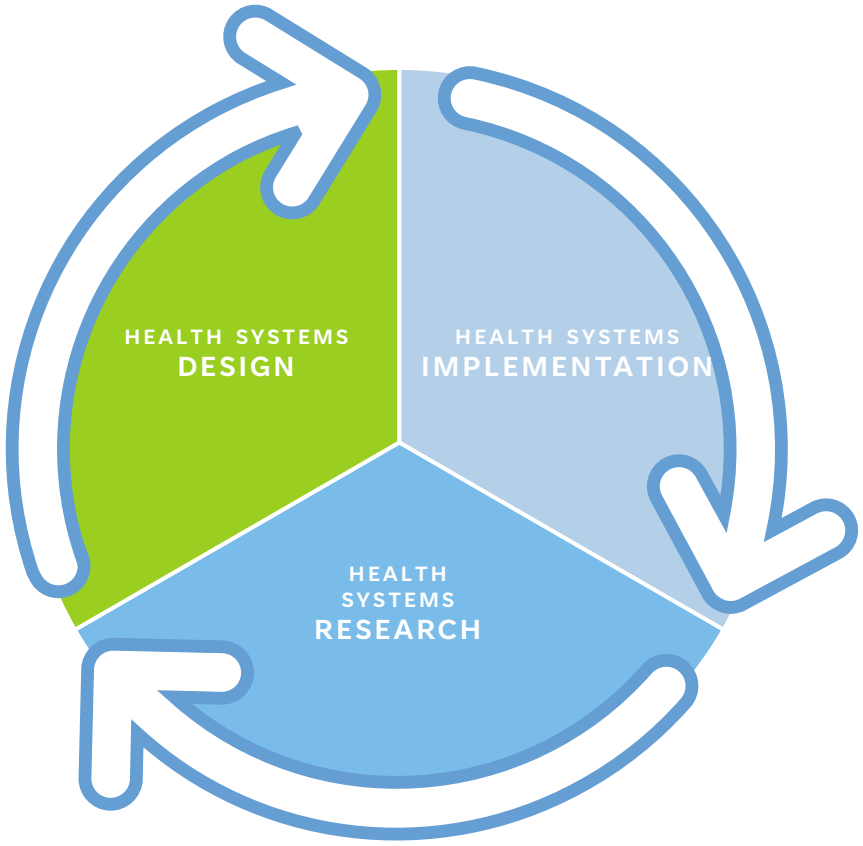
“integrating a system of health care for patients, improving the health of the overall population, and improving control over health care costs by promoting health maintenance, prevention, and care coordination and management.”

2010 Vermont Statutory Framework

Act 128 Mission of Blueprint For Health



BLUEPRINT FOUNDATION



DESIGN

Incorporate the innovation cycle - *design, implementation, and research* - into all initiatives and services

IMPLEMENTATION

Establish & sustain a network that can systematically test and implement innovative community-led strategies for improving health and well-being

RESEARCH

Rapidly respond to Vermont's health and social service priorities through statewide implementation of new initiatives and service models

THE BLUEPRINT MODEL

IMPROVE POPULATION HEALTH

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

ENHANCE PATIENT EXPERIENCE

- Improve quality of care
- Ease access
- Reduce cost

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...

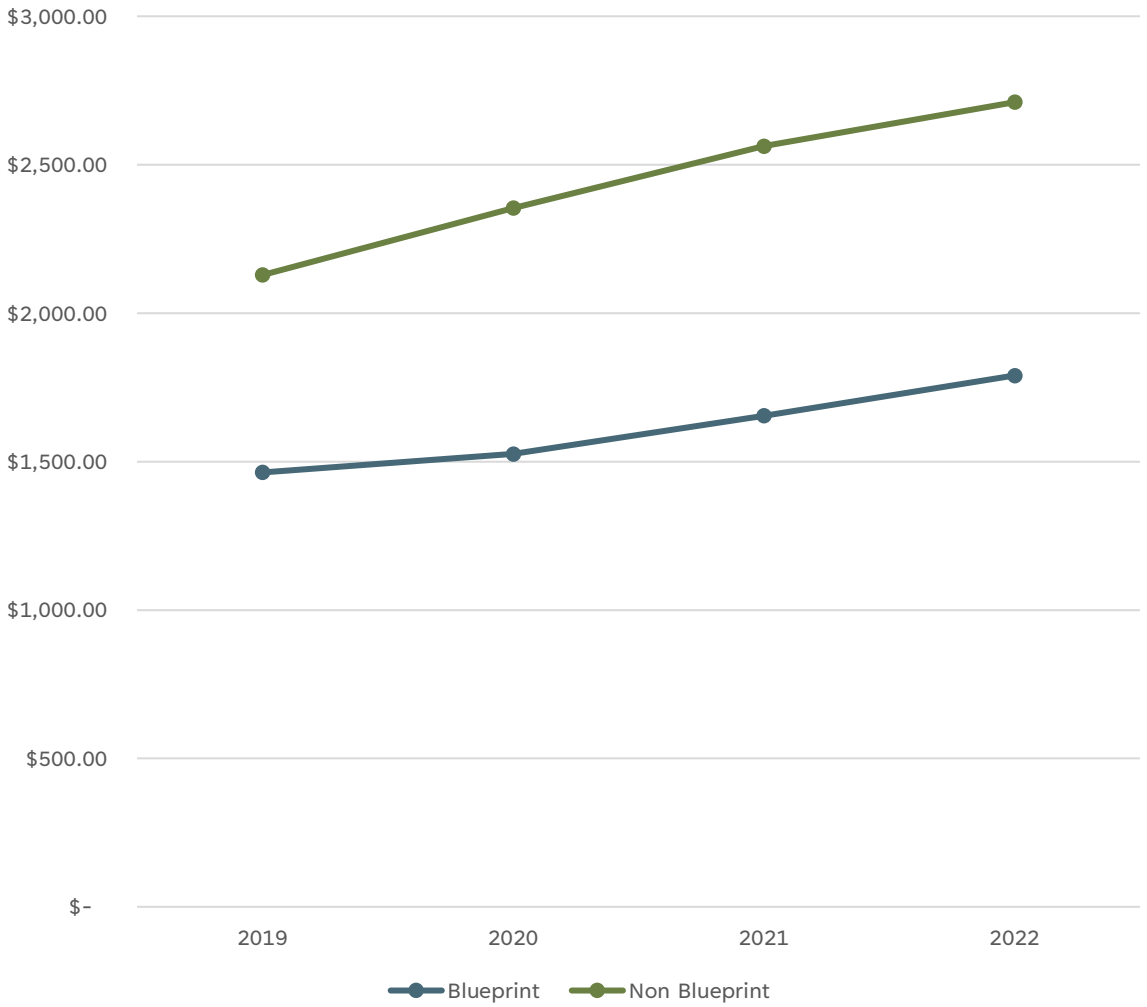
Full list available in Blueprint Manual

BLUEPRINT-ASSOCIATED COST-SAVINGS

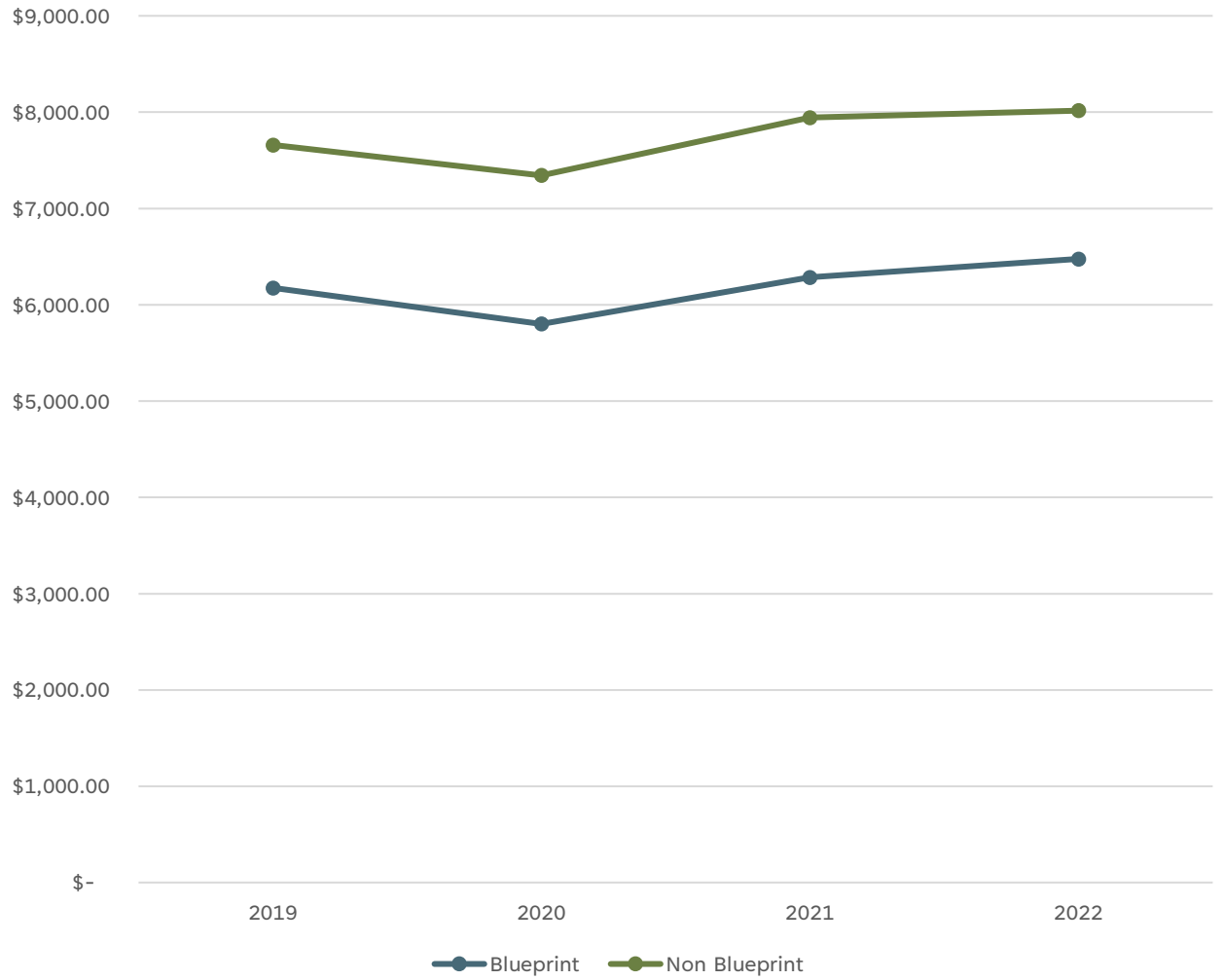
The 2017 Multi-Payer Advanced Primary Care Practice (MAPCP) Demonstration report revealed significant cost savings from Blueprint for Health programming (patient-centered medical homes, community health teams, and support and services at home) across 14 quarters

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

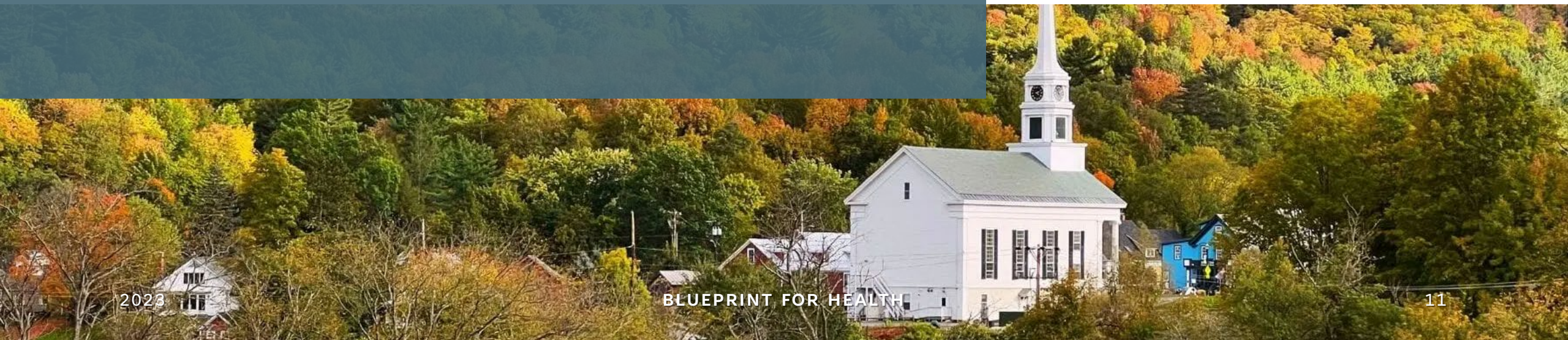


Dataset represents claims filed during these fiscal years that were reported to the VHCURES all payer claims database.

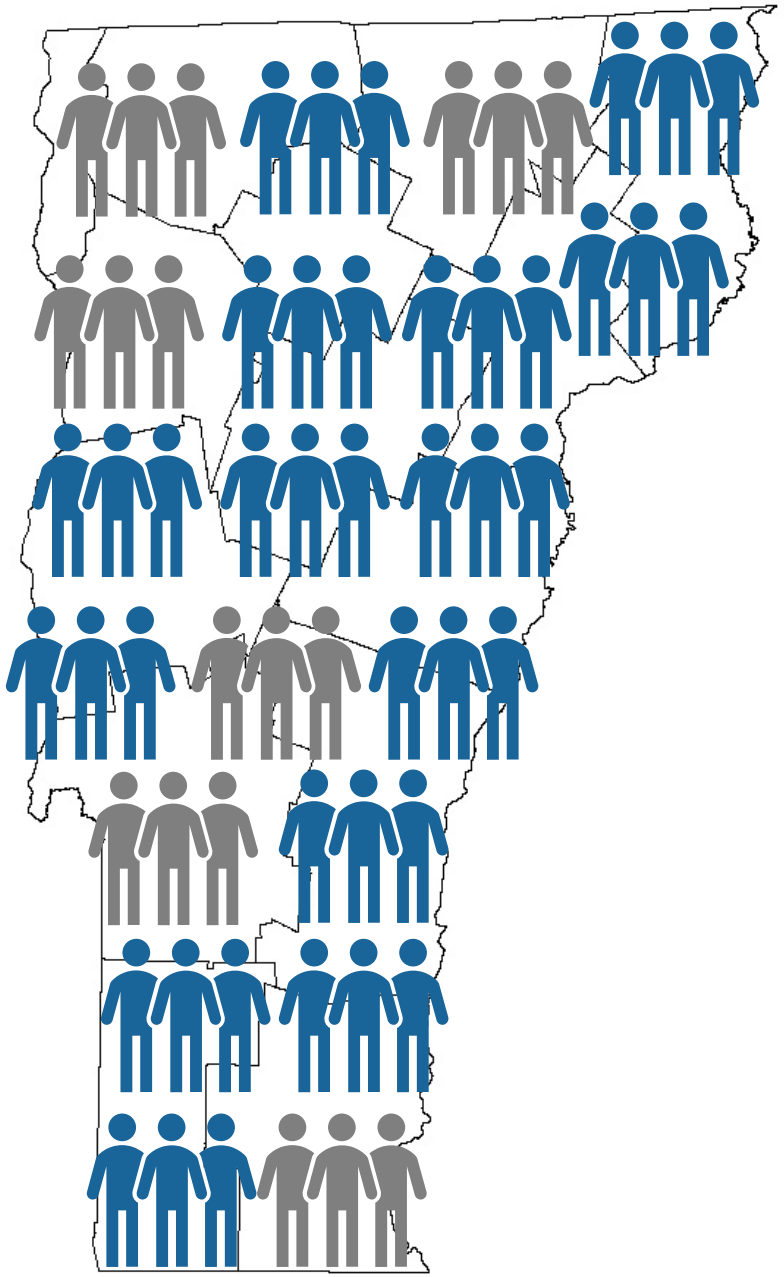
BLUEPRINT-ASSOCIATED OUTCOME IMPROVEMENTS

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

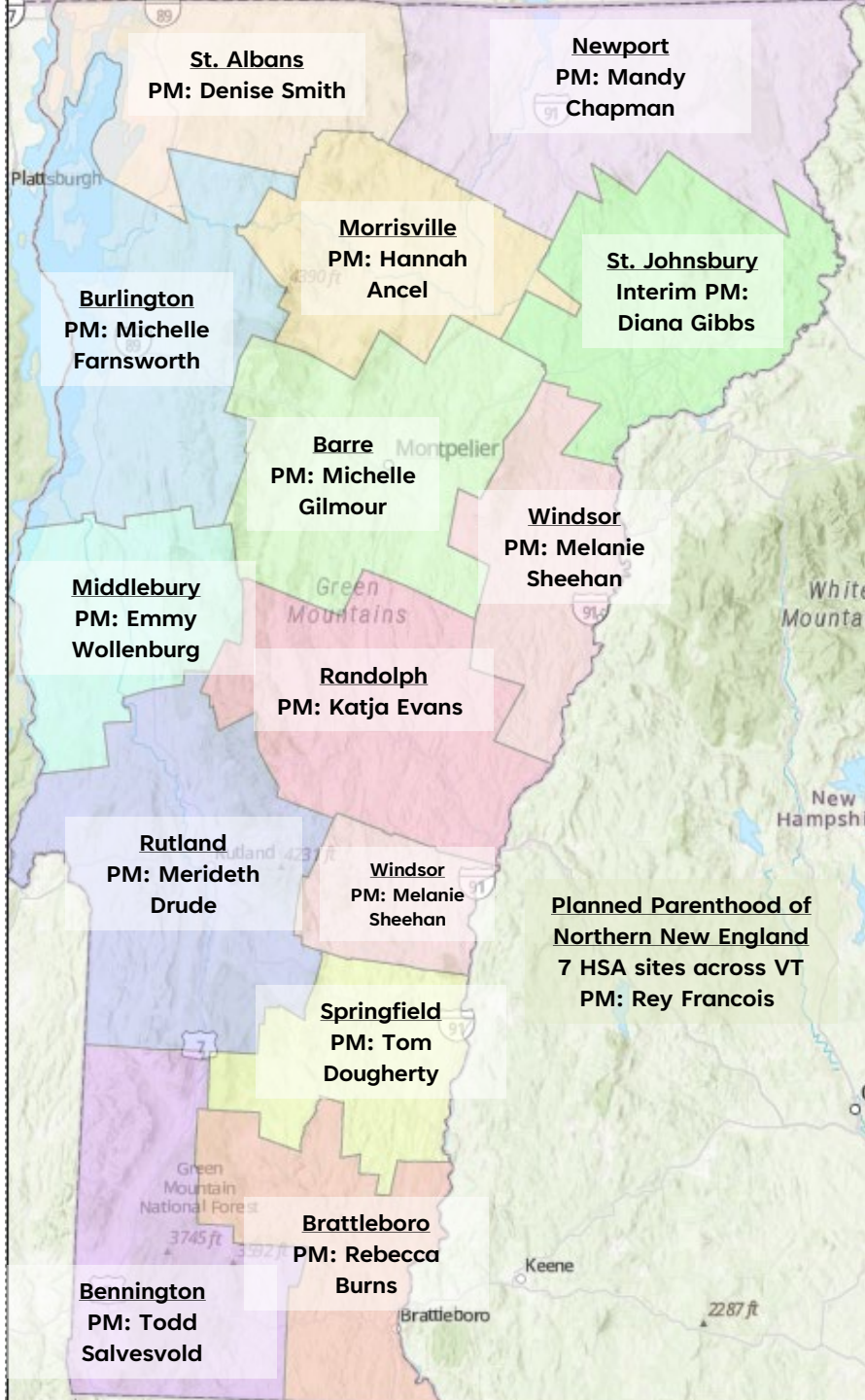


More than **70%** of Vermonters are seen in a Blueprint-supported Patient-Centered Medical Home.

HEALTH SERVICE AREAS

EACH ADMINISTRATIVE ENTITY HAS A PROGRAM MANGER

- is accountable for leading implementation and ongoing operations of the All-Payer Model (APM) and the Blueprint program in their HSA
- will receive multi-insurer payments to support hiring of Community Health Teams
- must be Centers for Medicare and Medicaid Services (CMS) eligible providers
- 13 Program Managers
  - CHT Leads
  - Quality Improvement Facilitators



PROGRAM MANAGERS

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

Monthly invoices per contract sent to:
AHS.DVHAInvoices@vermont.gov

BLUEPRINT PROGRAMS

- Patient-Centered Medical Homes
- Community Health Teams
- Hub & Spoke system of Opioid Use Disorder Treatment
- Pregnancy Intention Initiative

- Population data & 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 & Community	Care Management and Support	Care Coordination and Care Transition	Quality Improvement & Performance Management

PATIENT-CENTERED MEDICAL HOMES

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

COMMUNITY HEALTH TEAMS

Support primary care providers in:

- identifying root causes of health problems
- including mental health
- screening for social determinants of health

Connect Patients with:

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

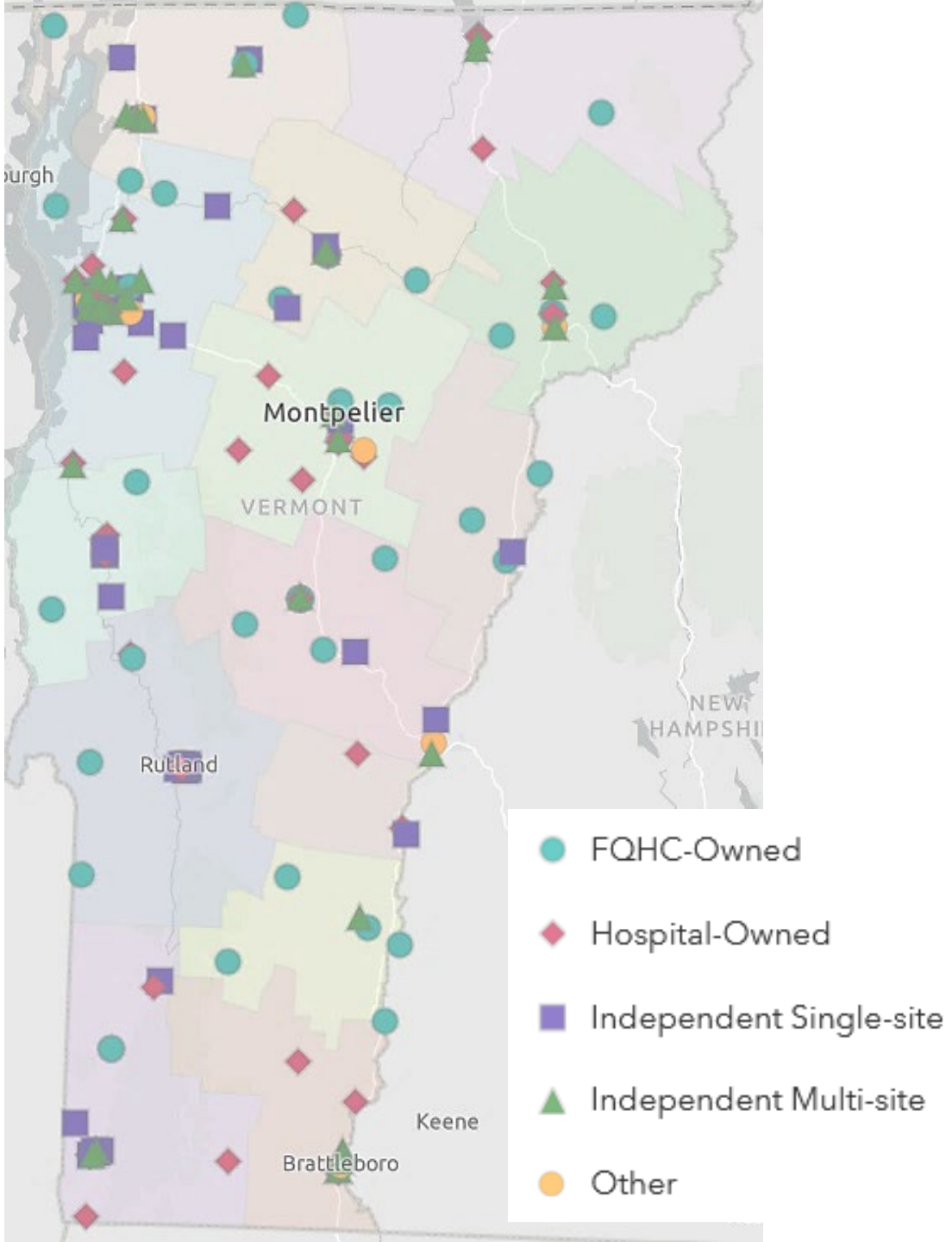
QUALITY IMPROVEMENT FACILITATORS

Improve:

- practice transformation as a PCMH
- population health quality and payment reform efforts
- clinical, cost, or patient experience priorities identified by the practice

Promote:

- Team-based care



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).

PCMH PAYMENTS

PER MEMBER PER MONTH (PMPM)

PCMH AFFILIATION TYPE

AFFILIATION TYPE	BP PRACTICE COUNT
FQHC-Owned	48
Hospital-Owned	42
Independent Multi-Site	13
Independent Single-Site	28
Grand Total	**131**

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**

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

PSYCHOSOCIAL SCREENING, INTERVENTION, AND NAVIGATION TO SERVICES

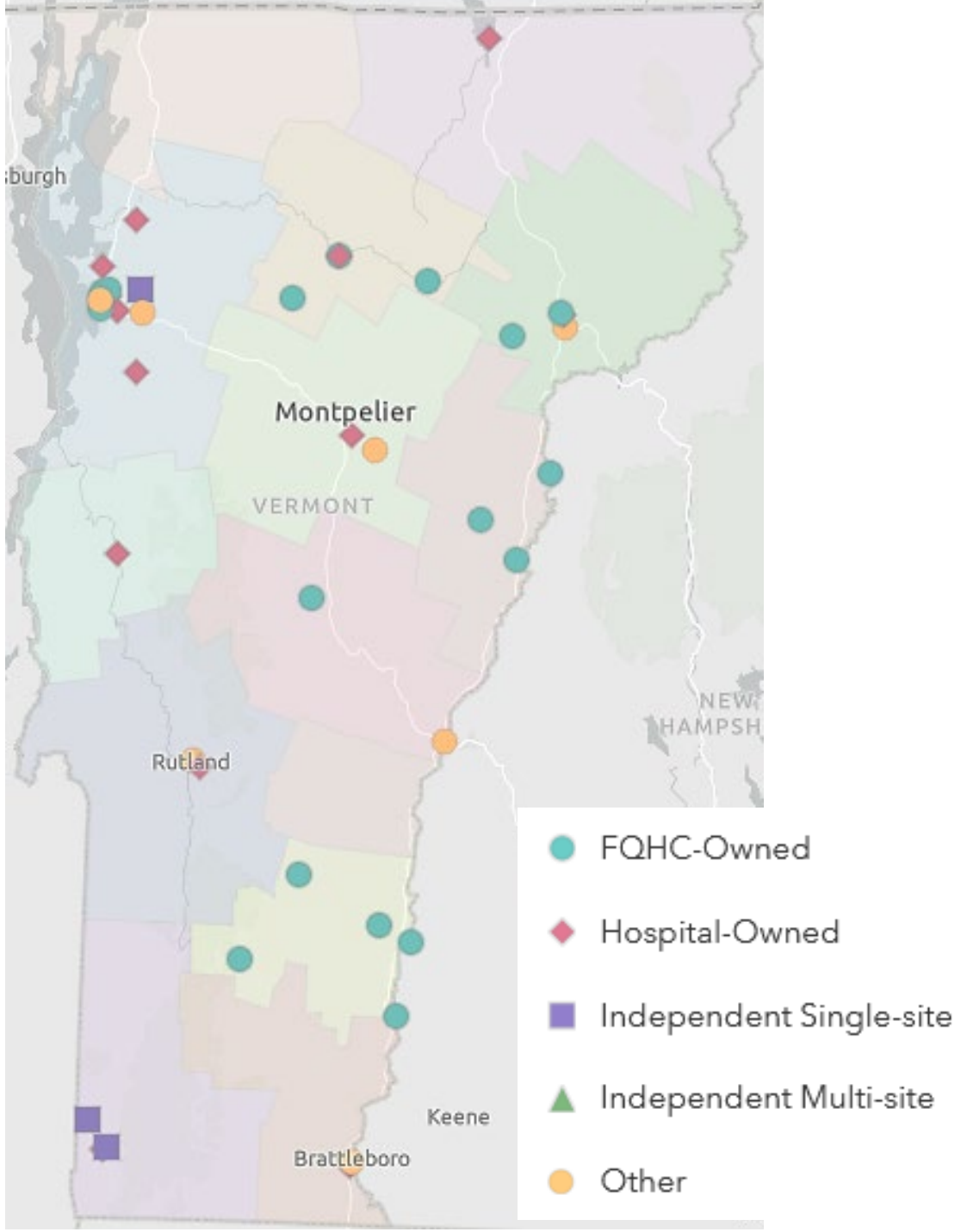
- Enhanced screening that includes Social Determinants of Health
- Brief intervention and referral/navigation to treatment and services
- Care coordination agreements with Primary Care/Community Partners

PREGNANCY INTENTION INITIATIVE SITES

PCMH OR specialty practices who agree to support building healthy families through discussion of Pregnancy Intention, Screening of Social Determinants of Health (SDOH) and same day access to contraceptive care if possible.

PAYMENT:

- Based on number of Medicaid patients ages 15-44 who had a qualifying claim
- Funding to support hiring a licensed counselor
- PMPM $1.25 to support administering the program

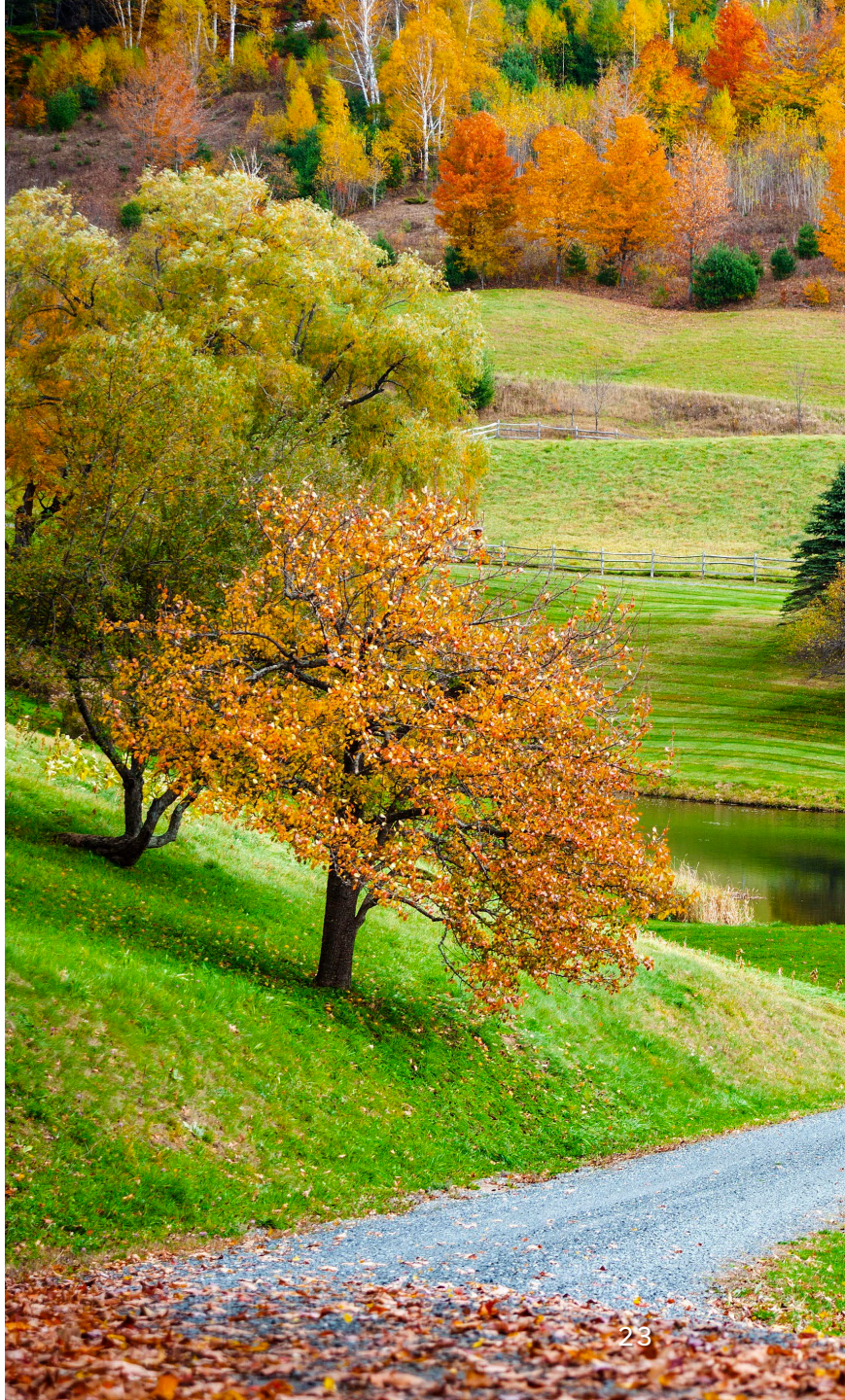


PARTICIPATING PRACTICES

PREGNANCY INTENTION

(PREGNANCY INTENTION INITIATIVE SPECIALTY PRACTICES IN BLUE)

Barre	- CVMC Women's Health - PPNNE - UVMMC Berlin
Bennington	- SVMC OB/GYN
Brattleboro	- Four Seasons OB/Gyn Midwifery - PPNNE
Burlington	- UVMMC Obstetrics and Midwifery - Champlain Obstetrics and Gynecology - PPNNE (2 Sites) - CHCB (5 sites) - UVMMC Family Med (4 sites)
Middlebury	- UVM Porter Medical Center
Morrisville	- The Women's Center - Hardwick Health Center - Lamoille Health Family Medicine (2 sites – Morrisville & Stowe)
Newport	- North Country OB/GYN
Randolph	- Gifford OB/GYN and Midwifery
Rutland	- Rutland Women's Health Care - PPNNE
Springfield	- Rockingham Health Center - Charlestown Family - Springfield Community Health Center - Ludlow Health Center - Mountain Valley
St. Johnsbury	- Danville Health Center - St. J Family Health Center - Women's Wellness Center - PPNNE
Windsor	- Little Rivers (3 sites) - PPNNE



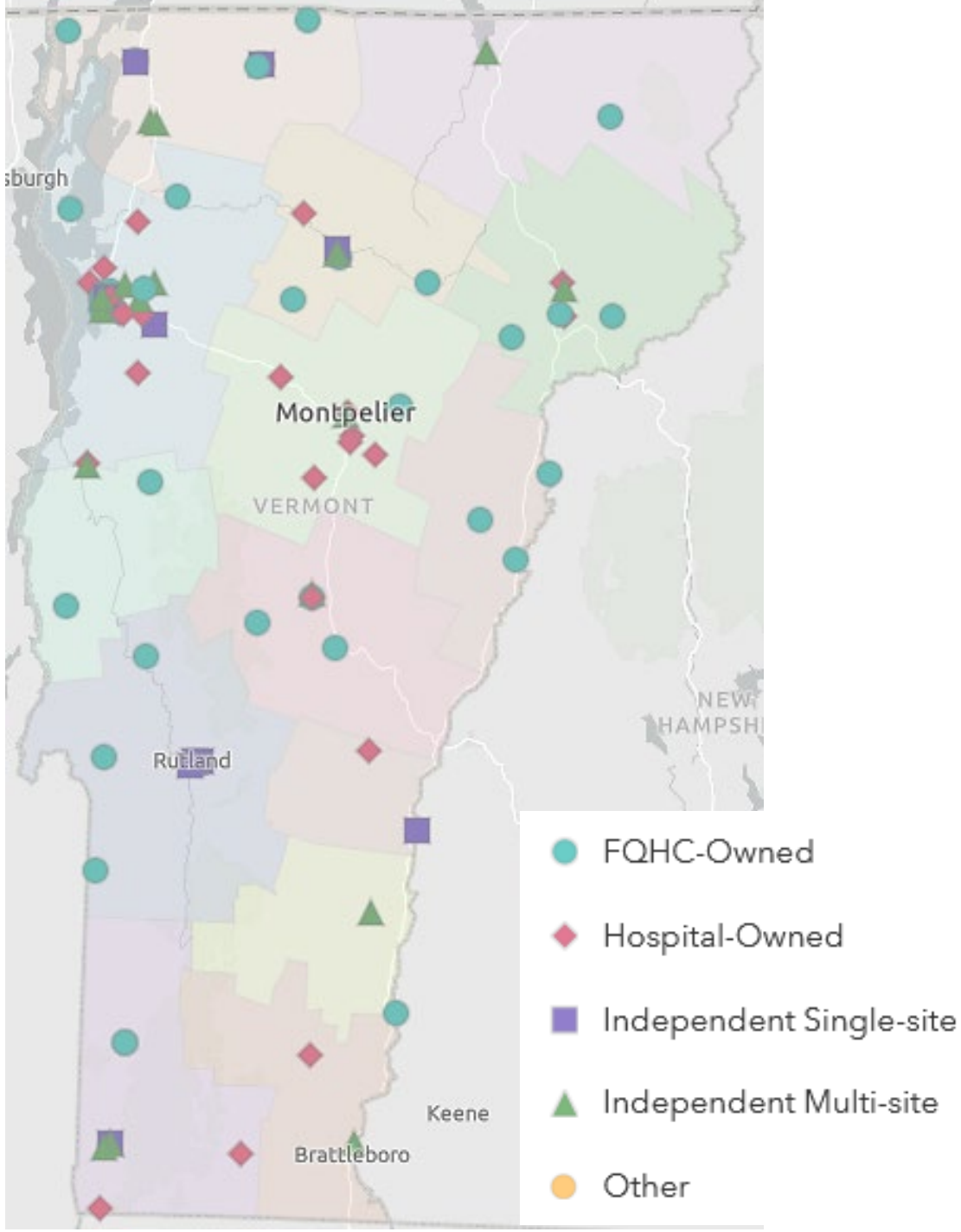
SPOKE SITES

Hubs (8 Opioid Treatment Programs) offer higher intensity services including daily medication and therapeutic support.
The Blueprint is responsible for Spokes Payment for Enhanced OBOTs (85 Office Based Opioid Treatment) to include health home services such as screening for depression, tobacco screening, and care management for Medicaid patients

Hired and deployed as part of Blueprint CHT though the administrative entity

PAYMENT:

- 1 FTE RN & 1 FTE Licensed Addiction/Mental Health Counselor for 100 Medicaid Members provide health home services. (Claims based on Buprenorphine/Vivitrol Prescriptions)



HUB AND SPOKE

MEDICATION FOR OPIOID USE DISORDER (MOUD)

- supporting people in recovery from opioid use disorder
- **very effective treatment** for most people

Two settings for MOUD designated by Federal Regulations

- Opioid Treatment Programs (OTPs)
- Office Based Opioid Treatment (OBOT)

HUB AND SPOKE PROGRAM

EST. 2013

HUBS

9 PROGRAM SITES

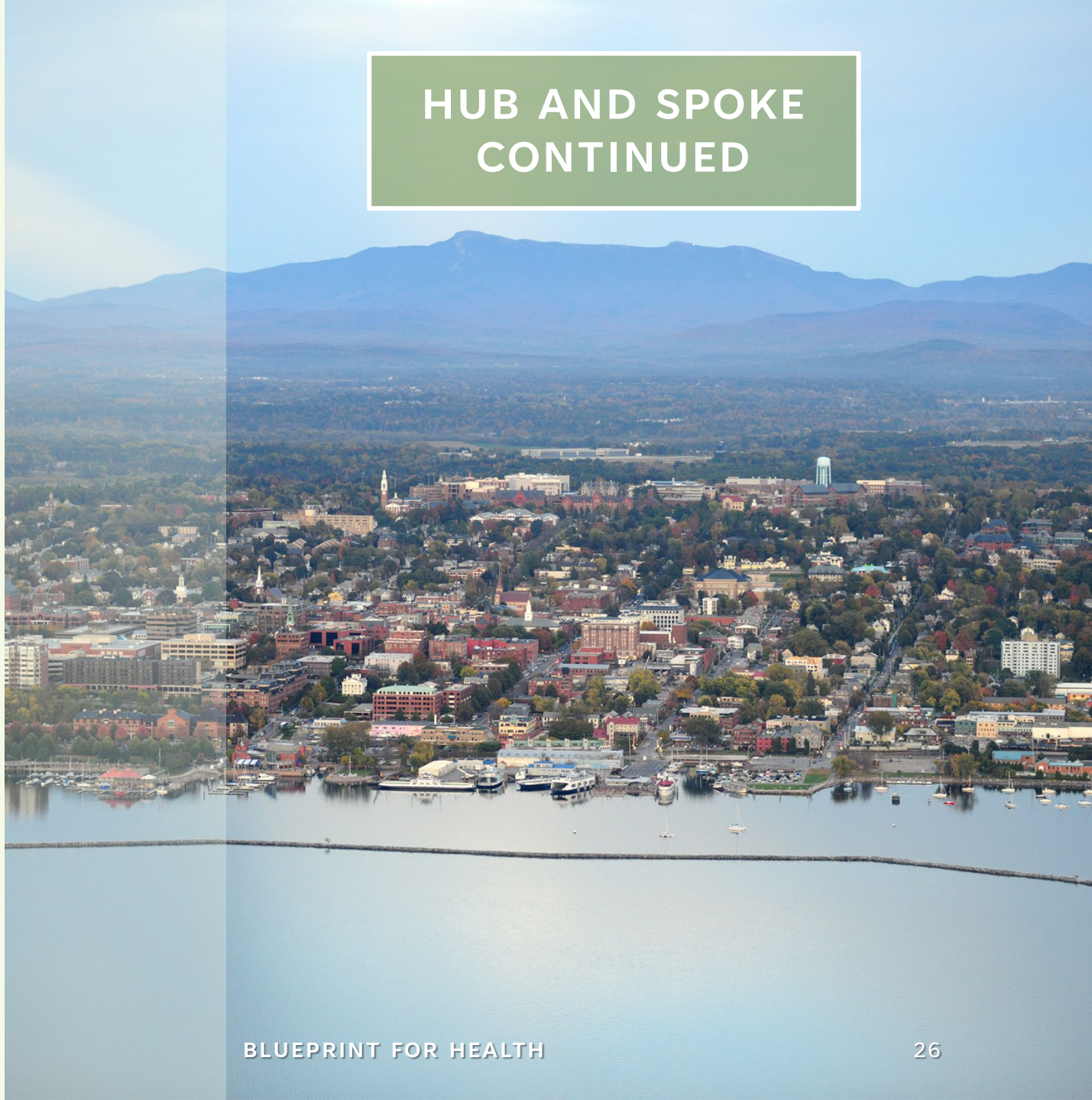
- Enhanced OTPs (Opioid Treatment Programs)
- Dispense Buprenorphine & Vivitrol addition to Methadone
- Augment staffing for health home services (care managers, counselors, nurses, and psychiatry)
- Monthly bundled rate

SPOKES

90 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)



HUB AND SPOKE CONTINUED

MEDICATION FOR OPIOID USE DISORDER
IN VERMONT SPOKES

Spoke Medicaid Patients Served

2013 Q1	2023 Q3
1,837 →	3,811

Spoke MOUD Prescribers

2013 Q1	2023 Q3
114 →	342

Spoke MOUD FTE Hired

2013 Q1	2022 Q2
7.6 →	74.3

COMMUNITY HEALTH TEAM

SUPPORT PRIMARY CARE PROVIDERS

- identifying root causes of health problems
- including mental health
- screening for social determinants of health

CONNECT PATIENTS

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

2023

FUNDED COMMUNITY HEALTH TEAM

- NURSES
- MENTAL HEALTH CLINICIANS
- CASE MANAGERS
- CARE COORDINATORS
- PANEL MANAGERS
- DIETICIANS
- COMMUNITY HEALTH WORKERS

COMMUNITY IS A WHOLE HEALTH TEAM

HOME HEALTH

DESIGNATED MENTAL HEALTH AGENCIES

PEERS

AND MANY MORE...

VERMONT CHRONIC CARE INITIATIVE

FOOD SHELF

HOUSING

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

SIX TYPES IN 2022

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

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**

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)*

EXPANSION WORKGROUP DEVELOPMENT

PROGRAM DESIGN
Screening
Referral workflow

- Social Determinants of Health
- Childhood developmental screening
- Substance Use
- Depression
- Housing
- Inter-partner violence

MEASUREMENT & EVALUATION
Outcome measures
Data collection processes

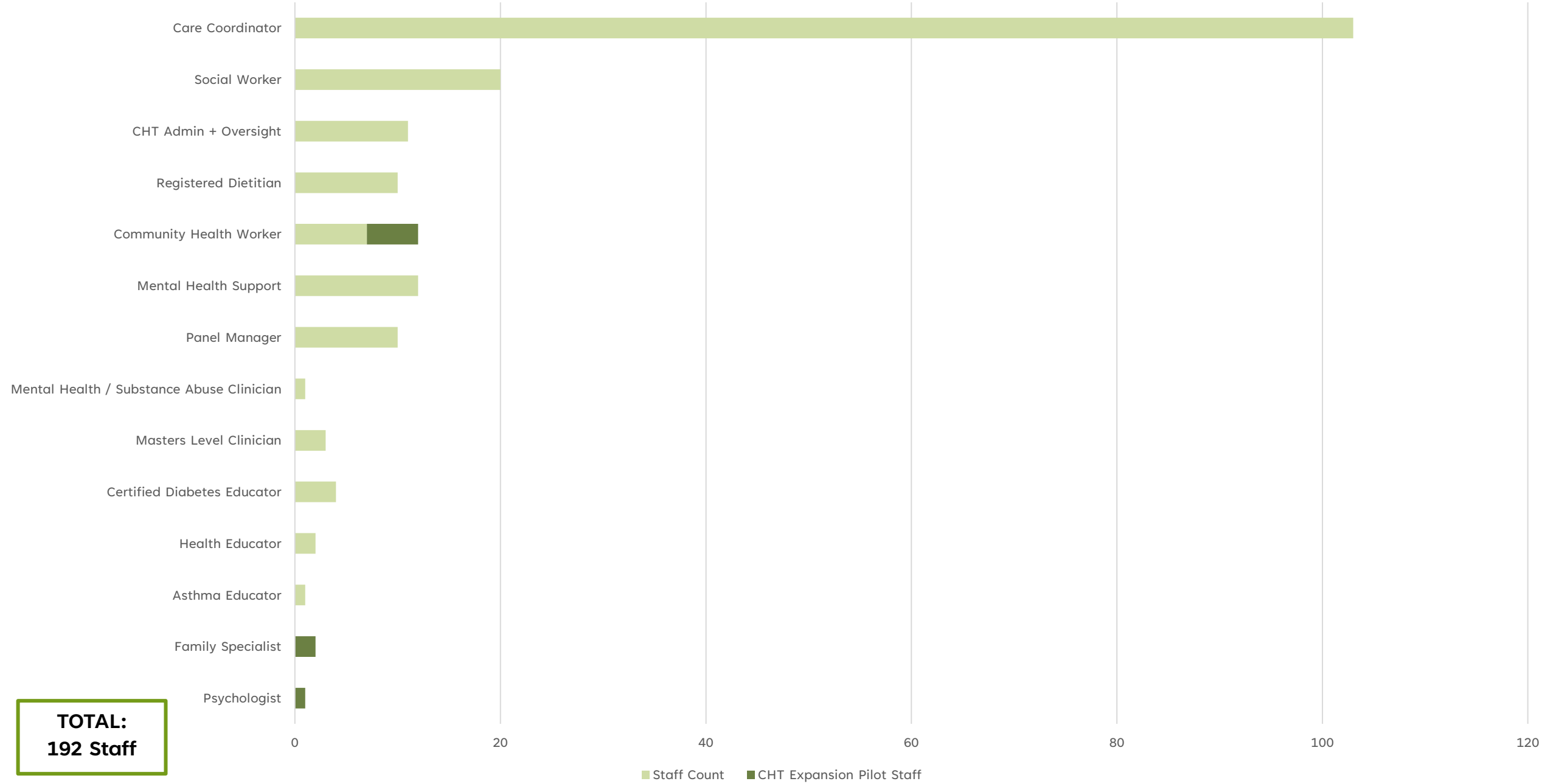
- Year 1 practice survey and chart review
- Year 2 Qualitative and Quantitative analyses

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

Community Health Team Staff Count Before & After Expansion

As of October 23, 2023



TOTAL:
192 Staff

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

THANK YOU

Julie Parker LCMHC, CCM

Assistant Director Blueprint for Health

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