Report to

The Vermont Legislature

Annual Report on
The Vermont Blueprint for Health

In Accordance with

18 V.S.A. §709: Blueprint for Health, Annual Report

Submitted to:	**House Committee on Health Care; Senate Committee on Health and Welfare; and Health Reform Oversight Committee**
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VERMONT

AGENCY OF HUMAN SERVICES

Department of Vermont Health Access

1 CONTENTS

2 ABOUT THE BLUEPRINT

The Vermont Blueprint for Health designs community-led strategies for improving health and well-being.

Current Blueprint programs include Patient-Centered Medical Homes, Community Health Teams, the Hub & Spoke system of opioid use disorder treatment, the Women's Health Initiative, Self-Management and Healthier Living Workshops, full population data and analytics for policy makers, communities, and practices, and a series of learning labs for providers and community teams.

The Blueprint's design work responds to the emerging needs of Vermonters and the latest opportunities in health and human services reform by creating change in the delivery system. This work began with patient-centered primary care and community health, then a system of treatment for opioid use disorder, and is now addressing the social determinants of health. The Blueprint Transformation Network of locally hired Program Managers, Community Health Team Leaders, and Quality Improvement Facilitators work with the accountable care organization (ACO) and community-based partners to lead the implementation of these innovations in practices and communities across Vermont.

The state-level Blueprint team is a unit within the Department of Vermont Health Access and collaborates with the Department's payment reform, quality, and clinical units. It also works closely with its external partners including OneCare Vermont, Bi-State Primary Care Association, and the Green Mountain Care Board.

Blueprint programs are continuously informed by comprehensive evaluations of health care quality and outcomes at the practice, community, and state levels. These evaluations have demonstrated that Vermonters served by Blueprint-supported programs have slower growth in health care costs and the same or better outcomes.

As the care delivery system and payment model evolve, the Blueprint's aim is constant: connecting Vermonters with whole-person care that is evidence-based, patient- and family-centered, and cost-effective.

3 EXECUTIVE SUMMARY

3.1 LEGISLATION & REPORT CONTENTS

18 V.S.A. § 709. requires the 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.

This report will provide information about the status of the Blueprint today. The program has evolved beyond the original "chronic care management plan" described in legislation but remains true to the original vision of all-payer supported, community-directed health reform that promotes the wellbeing of all Vermonters while slowing growth in cost. Last year's quantitative evaluation took a new approach, using the VHCURES population data to assess Blueprint and collaborating partner's efforts towards the goals established in the All-Payer ACO Model for population health, quality of care, and cost containment. This year's evaluation follows the same model.

3.2 SUMMARY OF BLUEPRINT 2019 FOCUS AREAS

The focus of health reform in Vermont has shifted to multi-payer provider-led reform supported by the All-Payer ACO Model Agreement. This Agreement sets the parameters for an integrated network of health providers to assume responsibility and risk for the health of the population and the cost of care. This Accountable Care Organization (ACO) approach builds on the foundation of the Blueprint for Health's primary care reforms. As the state's only ACO, OneCare Vermont is positioned to provide leadership across a growing network of providers, including primary care, and resources to support innovation in how the health care is paid for and delivered. The Blueprint is committed to supporting OneCare's work in all areas where Blueprint resources can be useful in promoting our shared goals. Some of these collaborations may include re-evaluation of patient medical home standards, alignment of incentives, focusing quality improvement efforts, and coproduction of data and analytics for quality improvement, population health work, and evaluation. In 2019, the Blueprint's work was conducted with an eye towards opportunities to capitalize on the strengths of both Blueprint and OneCare Vermont aligning efforts to achieving the All-payer Model goals. This includes the Blueprint's three main areas of focus for the year:

1) **Providing continued support to a network of local health reform leaders**, including Program Managers, Quality Improvement Facilitators, and Community Health

Team leaders. These roles provide local leadership for population health improvement activities, quality improvement, and implementation of the OneCare care model.

2) **Reviewing program portfolio and accelerating alignment with statewide health reform efforts** specifically with the OneCare Vermont ACO. Two program areas are targeted for closer alignment and integration: the work of the Quality Improvement Facilitators, an important asset to primary care practices that in the future may be most effective if based at OneCare, and the Self-Management Programs, which need a refreshed focus and format in order to meaningfully engage more Vermonters.

3) **Aligning investments in health information technology** to advance the availability of data for point of care, for quality activities, and evaluation. The Vermont Clinical Registry was closed at the end of 2019, and aligned investments supporting the health information technology based at Vermont Information Technology Leaders (VITL) were jointly planned by DVHA, OneCare Vermont, and other health reform leaders. This reduces the potential for redundant investments while continuing the work of developing aggregated, clinical data across health providers with the goal of advancing the quality, quantity and diversity of available data.

3.3 SUMMARY OF BLUEPRINT PROGRAMS IN 2019

- One hundred and thirty-three (133) primary care practices participate in the Blueprint for Health. These Patient-Centered Medical Homes provide evidence-based care consistent with national standards focused on care access, team-based care, patient/population health management, care management and support, care coordination and care transitions, and performance measurement and quality improvement. Over 100 of these practices are also members of OneCare Vermont.
- The Blueprint Community Health Teams supplement the care that is available in Patient-Centered Medical Homes, play an important role in patient and population health management, and link patients with the social and economic services that can help support healthy living.
- In 2019 Blueprint Community Health Teams implemented the OneCare Vermont care model, using OneCare's risk stratification tools to identify patients, engaging with those patients to understand their own health goals, and working with patients in multi-disciplinary care teams to coordinate their health care and social supports across providers and organizations.
- Participation in the Women's Health Initiative continued to grow, adding new women's health specialty practices and gaining full participation of the Planned Parenthood network.
- The Hub & Spoke program continued to add new medication-assisted treatment (MAT) prescribers in Spokes, expanding local capacity for opioid use disorder treatment.
- The Blueprint set new expectations for how Health Service Areas manage Self-Management Programs by requiring fewer workshops, encouraging focus on diabetes prevention and management and tobacco cessation programming, and asking for one innovative project in each Health Service Area to test new approaches. What the Blueprint learns from these changes will inform the Self-Management Programs redesign work mentioned in the 2019 focus areas summary above and discussed in depth in the Self-Management Programs section below.

3.4 SUMMARY OF THE QUANTITATIVE EVALUATION

In 2018 the Blueprint identified the need to systematically review health service utilization, expenditures, and outcomes for the whole population across payers and programs to understand trends and identify actionable opportunities to improve care. To do this, the Blueprint expanded the scope of its historical evaluation to include the whole population with data in VHCURES, not just Vermonters served in Patient-Centered Medical Homes. In order to reinforce the priorities identified in the All-payer Model and in the State Health Improvement Plan (SHIP), Blueprint focused the evaluation on measures related to the population health and cost containment goals of the All-Payer Model Agreement. Broadly these goals are:

- Limiting the annual growth in health care costs to 3.5% or less for included services;
- Increasing access to primary care;
- Reducing deaths from suicide and drug overdoses; and
- Reducing the prevalence and morbidity of chronic conditions (specifically COPD, diabetes, and hypertension).

Importantly, this is not an evaluation of the state's performance in the All-Payer ACO Model Agreement. Those evaluations and reports are conducted by the Green Mountain Care Board.[1] Rather, this report aligns the Blueprint evaluation with state priorities and targets established in the Agreement and the SHIP. Also, by broadening analysis to a full population approach and including all services, this report both provides context for trends seen among those engaged with Blueprint programs and identifies potential opportunities where collaboration between OneCare Vermont, the Blueprint and other state programs can support improvements in health care delivery.

The quantitative evaluation included in this report examines health care service utilization, expenditures, and quality outcomes for the population with data in VHCURES and specific subpopulations represented in Vermont's all-payer claims database over the previous six years (2013 – 2018) with the goals of:

1. Understanding trends in expenditures and utilization of health services over time, specifically the period after the Blueprint for Health program had a robust statewide presence;
2. Identifying areas that would benefit from improved care coordination and preventive care; and
3. Establishing baselines to monitor the impact of Blueprint and potential intersects with other health care reform efforts, on population health goals moving forward.

This evaluation reports on results for 463,633 Vermonters in 2018 and reviews changes between 2013-2018. The expenditure analysis aligns substantially with the Green Mountain Care Board's methodology for the All-Payer ACO Model's total cost of care calculation, but differs in that it includes services beyond those identified in the Agreement, such as retail pharmacy and

[1] GMCB reports on the All-Payer ACO Model are available at: https://gmcboard.vermont.gov/payment-reform/APM

Medicaid-covered mental health and substance abuse disorder treatment services. This expenditure analysis, similar to the All-Payer ACO Model Total Cost of Care calculation[2], also differs from the Green Mountain Care Board's Vermont Health Care Expenditure Analysis (VHCEA) in that it is limited to claims allowed amounts available for the VHCURES population and non-claim payments related to direct medical care such as care management and capitation. The VHCEA Resident analysis estimates all expenditures.

This report puts specific focus on examining expenditures and other measures for three primary care groups: Vermonters receiving most of their primary care from a Patient-Centered Medical Home, Vermonters receiving most of their primary care from other providers, and Vermonters who did not use primary care. In addition, it looks at three other populations of interest: Vermonters with opioid use disorder who receive MAT, those with opioid us disorder who receive other substance abuse treatment, and women age 15-44. Key findings follow. In many measures, trends by primary payer are also examined.

Expenditures

- Overall annual growth of per person expenditures between 2013-2018 across all categories is 2.8% when adjusted for inflation. Inpatient expenditures grew at the lowest rate of all categories while outpatient and pharmacy had the highest annual growth.
- The unadjusted and risk-adjusted expenditures for the Blueprint primary care group were lower than for the other primary care group despite Blueprint population having higher and increasing proportions with moderate and significant chronic conditions and significantly higher spending in special Medicaid services (SMS). While the crude annual growth was higher for the Blueprint population (3.1% vs. 1.8%), when adjusted for age, gender, health status, etc., those difference disappeared (1.5% vs. 1.5%). This finding supports the idea that well-coordinated advanced primary care continues to be associated with containment of health care costs.

  The Blueprint group had increasing rates of Emergency Department use yet lower rates of inpatient discharges and lower rates of total resource use than did the other primary care group.

Rate of Chronic Conditions

- Using claims data, this report found that the prevalence for chronic obstructive pulmonary disorder (COPD), diabetes, and hypertension has increased from 2013 to 2018 across most of the VHCURES population and subpopulations.
- While claims-based prevalence is not the metric used to assess the All-Payer ACO Model, this data can help identify for Blueprint leaders programmatic changes to meet the Agreement targets.

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[2] A summary of how the All-Payer ACO Model Total Cost of Care calculations differ from the Vermont Health Care Expenditure Analysis is available on slide four at: https://gmcboard.vermont.gov/sites/gmcb/files/2017_Expenditure_Analysis_with_projections_March_27_2019.pdf

- Patients of Blueprint Patient-Centered Medical Homes have a higher prevalence in each of the three conditions, and higher or equal to annual growth rates than the VHCURES population.

Primary Care Visits

- 90% of the Vermonters with data in VHCURES visited a primary care provider within the past two years (as of 2018).
- Claims data indicates that primary care utilization increased between 2013 and 2018; however, this trend does not indicate whether access is sufficient or convenient.
- The Blueprint Patient-Centered Medical Home group shows increases both for the rate of visits and the percent with a primary care visit each year, indicating that the higher rate is not simply driven by a small group of high utilizers.

Utilization

- Care is moving out of inpatient settings; a greater proportion of health care is happening in outpatient settings.
- Measures of initiation in treatment after a new diagnosis of alcohol or substance use disorder are 38% indicating opportunity for future improvement.
- Many health reform and quality improvement projects focus on the sickest members of the population, whose care represents a large proportion of health care spending. This evaluation finds plausible opportunity for reducing potentially unnecessary healthcare utilization amongst healthier people.
- By 2018 most Medicaid members with diagnosed opioid use disorder received MAT. The members receiving MAT had lower medical services utilization than did those who received other types of substance abuse treatment.
- The VHCURES population showed a reduction in Emergency Department (ED) visits over time although the Medicare sub-population showed increased ED use. The rate of Inpatient Discharges per member per year increased for all groups between 2013 and 2018.

4 THE BLUEPRINT IN 2019

In 2019 the Blueprint focused on providing continued support to a network of local health reform leaders, on reviewing program investments in health information technology , and on planning for a future where the Blueprint's work is more closely aligned with other statewide health reform efforts, including with the OneCare Vermont accountable care organization.

4.1 SUPPORTING LOCAL HEALTH REFORM LEADERSHIP

Blueprint investments fund a network of local health reform leaders, including Blueprint Program Managers, Quality Improvement Facilitators, and Community Health Team Leaders. The Blueprint's current objective is to continuously strengthen their local health systems so that those systems can effectively manage risk contracts, provide care coordination, and advance population health. These positions are funded by grants made to the local administrative entities, which in all but one case are the local hospitals. These same local hospitals are all OneCare participants, so these leaders work on behalf of both the Blueprint and OneCare. The effectiveness of investing in local health reform leadership was first quantitatively demonstrated in national evaluations of Patient-Centered Medical Home initiatives where the Blueprint was shown to reduce the cost of medical care for patients in participating practices, while most other medical home initiatives did not. The most notable difference in the Blueprint's approach was its funding of a network of local health reform leaders and Community Health Teams. In addition to funding this network, the Blueprint provides participants with oversight, coaching, educational offerings, and peer-to-peer learning opportunities.

4.2 ALIGNING AND SUPPORTING STATEWIDE HEALTH REFORM EFFORTS: REVIEWING PROGRAM INVESTMENTS AND REDESIGNING TWO INITIATIVES

In 2019, while continuing its commitment to support a shared network of local health reform leadership, the Blueprint began reviewing all programmatic investments to assess whether they are 1) achieving their intended results and 2) are best managed by the Blueprint or transitioned to partners. By the end of 2019, this review identified two areas of focus that could benefit from further integration and alignment with OneCare Vermont. The first is the Blueprint Quality Improvement Facilitators. The Quality Improvement Facilitators are professional coaches trained in health care quality improvement and change management. They are also experts on the NCQA Patient-Centered Medical Home standards. They work directly with primary care practices to support Patient-Centered Medical Home recognition and ongoing quality improvement. In addition, they provide in-practice supports to Spokes and Women's Specialty Care practices. Providers and practice staff often recognize these Quality Improvement Facilitators as essential members of their practice teams; the investment in this resource is sound. At this time the Blueprint recommends that primary care quality assurance and quality improvement functions would be best led by a provider organization. The Blueprint and OneCare Vermont are currently discussing how this function may be transitioned to OneCare Vermont. The advantages of basing this function at OneCare Vermont include better alignment between the work of the Quality Improvement Facilitators and the OneCare Vermont Clinical Consultants, which potentially streamlines the requirements for primary care practices and reduces risk of overlapping or redundant investments. In addition, OneCare and the Blueprint have the opportunity to capitalize on their collective strengths aligning efforts to work with

providers to continue to advance innovations in primary care and coordination across the system of care. Collaboration may include re-evaluation of patient medical home standards, alignment of incentives, focusing quality improvement efforts on key priorities, researching and piloting models of care, and coproducing of data and analytics for quality improvement in primary care.

The second program that the Blueprint is exploring changing is Self-Management. The Self-Management Programs launched early in the Blueprint's history offer evidence-based classes directly to patients on topics like healthy living with diabetes, diabetes prevention, tobacco cessation, mental health and emotional well-being, and living well with chronic pain. Many Vermonters have participated and benefited from these classes over the years. For some, a class marked the beginning of a profound personal health transformation. Recently, enrollment has declined, heath service areas have struggled to staff and run classes consistently, some providers have expressed reluctance to refer to programs only offered episodically, and patients have expressed interest in more one-on-one, personalized, and flexible health education offerings. The Blueprint is currently working with partners at OneCare Vermont, RiseVT, and the Vermont Department of Health in a redesign process that will include collecting input from stakeholders, engaging patients to understand their needs and ideas, considering national best practices in patient education and engagement, and ultimately reimagining the self-management offerings. In addition to developing new education experiences for patients, it is likely that the planning team will recommend moving administration of these resources to OneCare Vermont.

4.3 SHARING INVESTMENTS IN HEALTH INFORMATION TECHNOLOGY

In 2019 the Blueprint also shifted its approach to advancing the aggregation of clinical data and the transformation of clinical data into information. The Blueprint recognizes the importance of clinical data for improved point of care services, for quality improvement, for measuring population health, and for program evaluation. In previous Annual Reports, the Blueprint has described its work to stand up the Vermont Clinical Registry. That registry relied on legacy software no longer supported by the IT company that created it, so in 2019 the Blueprint began exploring future option. An opportunity was identified to concentrate public investment in a single clinical data platform, housed at Vermont Information Technology Leaders (VITL) and serving the Blueprint, OneCare, and other health reform partners. At the end of 2019, the Blueprint retired the Vermont Clinical Registry and began participating in scoping the new, shared data platform at VITL. Sharing investments in one platform will reduce the likelihood of duplication and make all available resources go further. The goal is that this approach will allow a team of collaborating organizations to further the strategic vision for health data, advancing the quality, quantity and diversity of information available to support care, enhance quality, and evaluate and inform healthcare policy.

5 BLUEPRINT PROGRAMS

5.1 PATIENT-CENTERED MEDICAL HOMES

5.1.1 About Patient-Centered Medical Homes

The Blueprint supports Vermont primary care practices in becoming Patient-Centered Medical Homes, recognized by the National Committee for Quality Assurance (NCQA), which provides the most widely used standards for advanced primary care. NCQA requires practices to demonstrate annually that they provide care that meets a set of criteria organized under the following six concepts:

- Team-Based Care and Practice Organization
- Knowing and Managing Your Patients
- Patient-Centered Access and Continuity
- Care Management and Support
- Care Coordination and Care Transitions
- Performance Measurement and Quality Improvement

The Blueprint's Quality Improvement Facilitators support practices in understanding the Patient-Centered Medical Home model and NCQA's standards, developing systems that meet or exceed them, and achieving and maintaining Patient-Centered Medical Home recognition. Between annual NCQA reporting periods, Facilitators work with practices on ongoing quality improvement activities, which may focus on ongoing practice transformation, health and payment reform goals and efforts, or quality improvement opportunities identified by the practice, organization, or community.

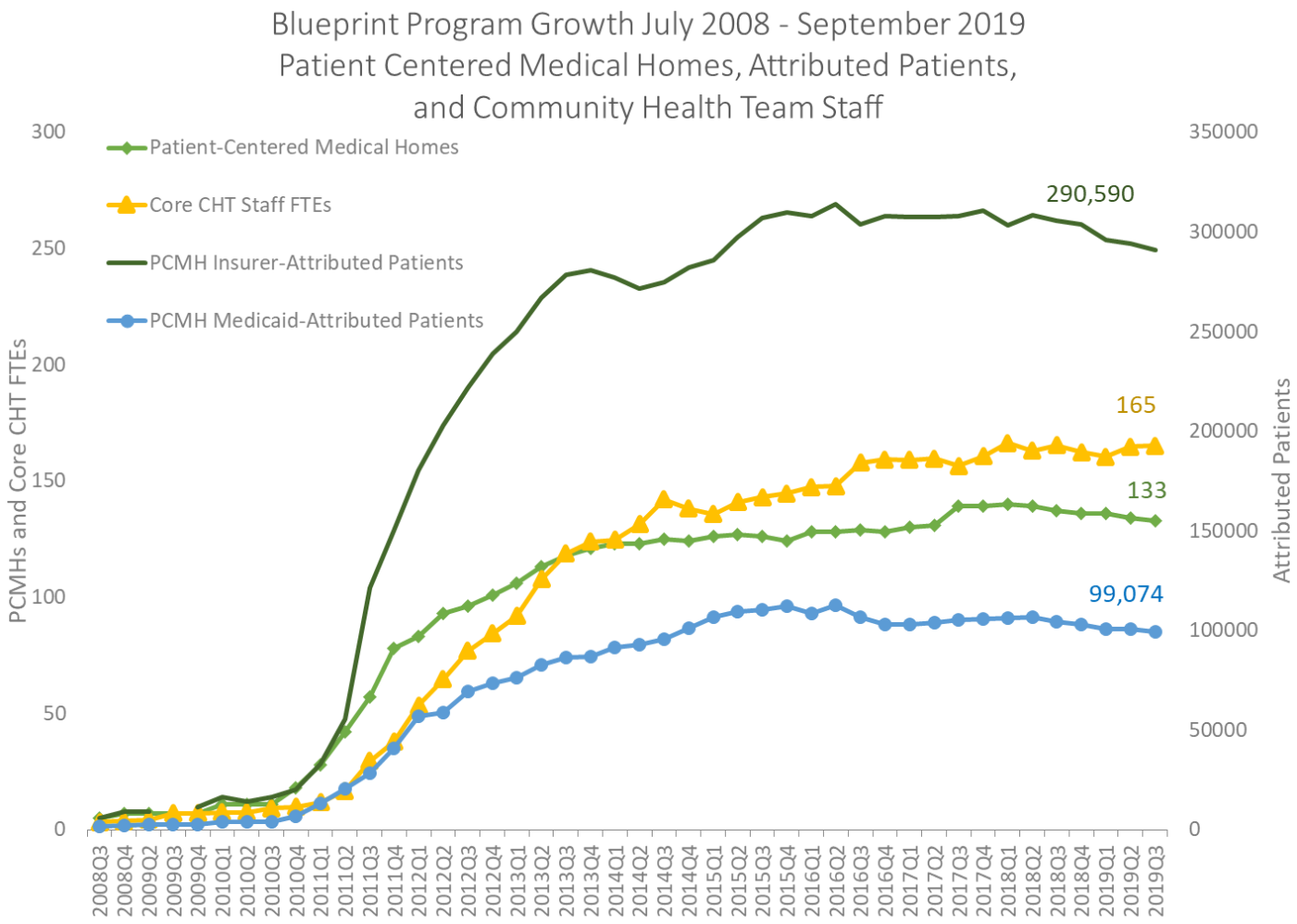
Payers (Medicaid, Medicare, Vermont's major commercial insurers, and some self-insured businesses) support practice transformation and ongoing quality improvement activities with a per member per month payment to each Blueprint-participating Patient-Centered Medical Home. An additional performance-based payment promotes improvements in rates of preventative care and management of chronic conditions. The participation payment has supported Patient-Centered Medical Homes since 2008 and represents an early example of payment for quality instead of service volume and of all-payer alignment around payments to support shared goals.

5.1.2 Patient-Centered Medical Homes in 2019

Almost all of Vermont's primary care practices participate in the Blueprint for Health. At the end of the third quarter of 2019, 133 practices were participating. In 2019, one practice chose to join the Blueprint. Five participating practices closed in 2019.

The following chart shows the growth of the Blueprint program over time, including the number of participating Patient-Centered Medical Homes, the number of Community Health Team staff (counted by full-time equivalent (FTE) positions), and the number of patients across all participating payers attributed to Patient-Centered Medical Homes (based on having received more of their primary care services in those practices than in any other over a two year period).

Figure 1: Blueprint PCMHs, CHT Staff, and Patients



5.2 COMMUNITY HEALTH TEAMS

5.2.1 About Community Health Teams

The Blueprint Community Health Teams supplement the care that is available in Patient-Centered Medical Homes, support patient and population health management, and link patients with the social and economic services that can support healthy living. Their staffing and service configuration is determined by local Blueprint leadership in consultation with their Community Collaborative or Accountable Community for Health group. Services may include:

- Population specific (panel) management and outreach
- Screening for social determinants of health
- Mental health screening
- Health coaching
- Clinical nutrition support
- Individual care coordination
- Brief counseling
- Substance abuse treatment support
- Condition-specific wellness education
- Navigation to additional community-based services in areas like mental health, housing, employment, transportation, and more

Community Health Teams are funded by Medicaid, Medicare, Vermont's major commercial insurers, and some self-insured businesses. Their services are offered barrier-free to patients and practices (meaning no co-payments, no prior authorizations, and no billing). This shared utility, supported by all payers, is uniquely flexible and responsive to local needs and conditions.

5.2.2 Community Health Teams in 2019

The Blueprint Community Health Team staff implement the OneCare care model to help people at high risk of health problems achieve better health outcomes. Community Health Team staff in OneCare participating communities use OneCare risk stratification tools to identify individuals who can benefit from care coordination. OneCare's plan for slowing the growth of health care expenditures includes providing care coordination to help people manage chronic disease in community and primary care settings and avoid more complex and costly hospital-based care. In 2019 and 2020 the Blueprint is offering trainings that support Community Health Team staff's work with patients such as motivational interviewing, Zero Suicide, and understanding complex physical health needs.

Community Health Team leaders and staff have also been active participants in the Community Collaboratives or Accountable Community for Health groups in each Health Service Area in 2019. They helped envision and implement community-wide quality improvement projects that brought health care and human service providers together to address high-priority population health concerns. More information about these projects can be found in the Health Service Area Highlights section of this report.

5.3 WOMEN'S HEALTH INITIATIVE

5.3.1 About the Women's Health Initiative

Women receive primary care and preventative care services in both Patient-Centered Medical Homes, obstetrics and gynecology practices, and Planned Parenthood. Through the Women's Health Initiative, all of these settings are offering the women they serve enhanced health and psychosocial screening, comprehensive family planning counseling, and timely access to long acting reversible contraception (LARC). The aim is to help women be well, avoid unintended pregnancies, and build thriving families.

Women who visit participating practices are screened for mental health and substance use conditions, interpersonal violence, and access to housing and food. If they are identified as at-risk, they have immediate access to a licensed social worker for brief intervention, counseling, and navigation to community-based services and treatment as needed.

Participating practices also commit to offering comprehensive family planning counseling for their current patients and for women newly referred by partnering community-based organizations. Women who wish to become pregnant receive services to support healthy pregnancy. Women who wish to delay or avoid becoming pregnant have access to the full spectrum of contraception options, including same-day access to LARC.

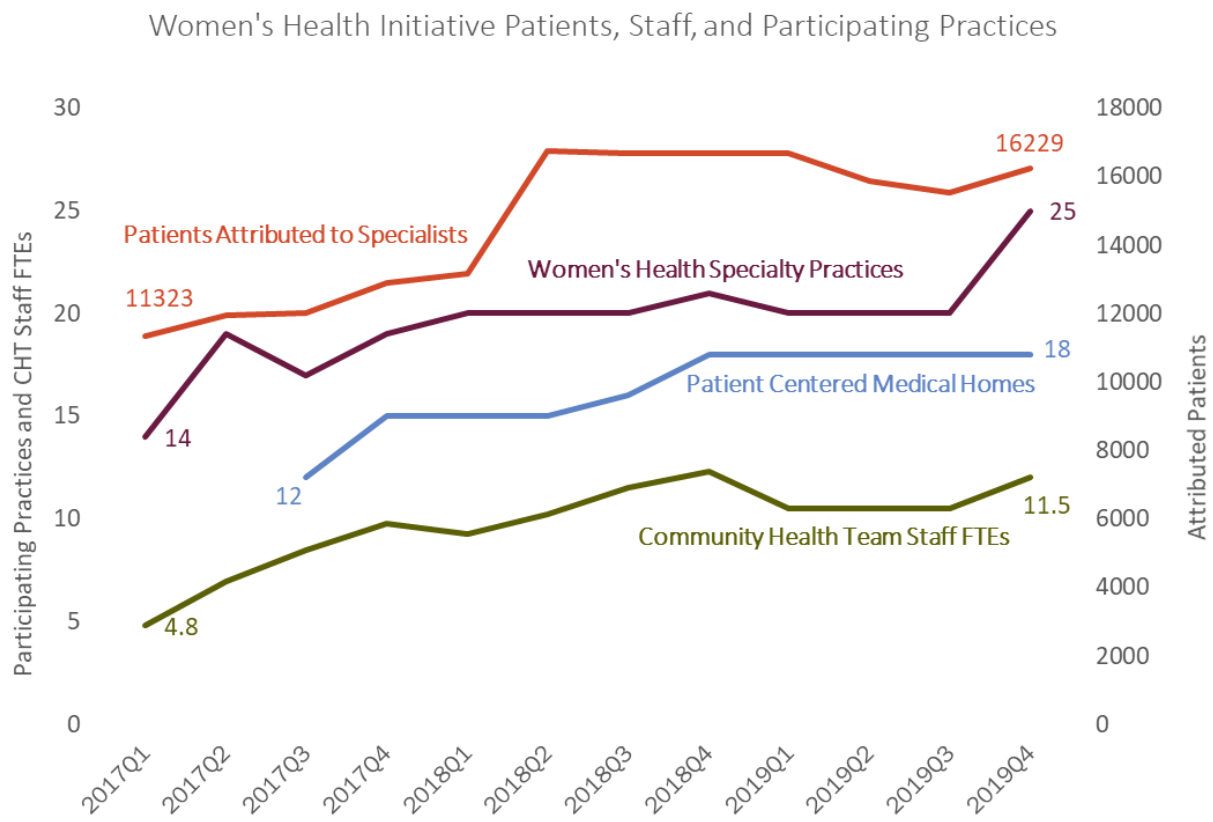
Additional information about the Women's Health Initiative, including the payments that support the work, can be found on the Blueprint for Health website.

5.3.2 Women's Health Initiative in 2018

Launched in 2017, the Women's Health Initiative continued to expand in 2019. Program growth is shown in Figure 2.

- The Women's Health Initiative is currently paid for by Medicaid only. While members of commercial insurance plans may receive services, the Blueprint only measures Medicaid members served. At the end of 2019, the Women's Health Initiative was serving 16,229 Medicaid members who received services at women's health specialty practices.
- At the end 2019, the Women's Health Initiative includes 25 women's health specialty practices out of an estimated 30 women's health specialty practices operating in Vermont.
- All twelve Planned Parenthood practices are now participating in the Women's Health Initiative. This partnership is important to the initiative's scale and success in serving Vermont women.
- At the end of 2019, the Women's Health Initiative included 18 Patient-Centered Medical Homes that provide reproductive health services.

Figure 2: Women's Health Initiative



5.4 HUB & SPOKE

5.4.1 About Hub & Spoke

Hub & Spoke is Vermont's system of medication-assisted treatment (MAT), supporting people in recovery from opioid use disorder. Nine regional Hubs (or "opioid treatment programs") offer daily support for patients with complex addictions. At over 90 local Spokes (or "office-based opioid treatment"), doctors, nurses, and counselors offer ongoing opioid use disorder treatment fully integrated with general health care and wellness services. The Blueprint administers the Spoke part of the Hub & Spoke system.

Spokes are settings where opioid use disorder treatment is integrated into general medical care, like treatment for other chronic diseases. These settings are mostly primary care or family medicine practices and include obstetrics and gynecology practices, specialty outpatient addictions treatment programs, and practices specializing in chronic pain. Prescribers in Spoke practices are physicians, nurse practitioners, and physician assistants who are federally waivered to prescribe buprenorphine. They may also provide oral naltrexone or injectable Vivitrol. Spokes receive specialized staff – one nurse and one licensed mental health / addictions counselor for every 100 Medicaid patients receiving medication-assisted treatment (MAT). The new staffing helps expand access to treatment by providing prescribers with multi-disciplinary teams to see patients more frequently, proactively monitor care, and coordinate patient care across health and human services systems. For patients, specialized Spoke staff are essential members of their care team; they work together towards long-term recovery and improved health and well-being. The Blueprint and the Vermont Department of Health's Division of Alcohol and Drug Abuse Programs (ADAP) offer ongoing training to Spoke prescribers and teams. More detail about the structure and impact of the Hub & Spoke System can be found on the Blueprint website.

5.4.2 Hub & Spoke in 2019

In 2018 the Blueprint helped expand access to treatment and improve quality of care for opioid use disorder:

- Figure 3 below shows the growth of the Spoke program, including the number of providers, spoke staff, and patients. The number of Medicaid beneficiaries receiving treatment in Spoke settings grew from 2,887 in the third quarter of 2018 to 3,227 in November 2019.
- 260 prescribers offered MAT in Spoke settings in November 2019, up from 232 in the third quarter of 2018. 74 of these prescribers treated ten or more individuals with opioid use disorder, up from 69 at the same time last year.
- Specialized Spoke staff – the nurses and licensed mental health professionals working with medication assisted treatment patients in Spoke settings – included 70.2 full time equivalent positions in November 2019 compared to 59.1 at the end of the third quarter of 2018.
- A team including Blueprint and VDH-ADAP staff designed and hosted a series learning session for Spoke providers and practice teams in 2018 and 2019. The last session in this series was held in the first quarter of 2019. Sessions featured research and clinical experts, including peer Spoke prescribers. The focus of the series was improving transitions between Hubs and Spokes, use of harm reduction strategies, use of Vivitrol, and supporting more comprehensive services for wellness and recovery strategies.

- In 2019, the Blueprint worked with VDH-ADAP to plan the next series of learning sessions, which will begin in January 2020. The format will include half-day regional in-person events, webinars, and a statewide conference for the Hub & Spoke network. The curriculum, developed with Dartmouth faculty, covers a wide range of topics including two-generational care, addressing trauma and building resiliency, and caring for patients who may be injecting buprenorphine.
- VDH-ADAP administers the Hub part of "Hub & Spoke." Hubs continue to report no waitlists and the total caseload increased from 2018 with 3,570 patients seen in the second quarter of 2019.The number of Hub and Spoke patients (all-payers) is shown in below.
- The Blueprint continued working with Medicare and commercial payers to design payment approaches that would make them full participants in the Hub & Spoke system. BlueCross BlueShield of Vermont and MVP implemented pilot approaches in 2019. Beginning in 2020 Medicare will also pay for Hub and Spoke services due to changes in Federal law.
- In an effort to reduce the number of fatalities from drug overdoses local Hub and Spoke leaders are trying new approaches to increasing access to treatment such as offering buprenorphine induction in emergency departments and making buprenorphine available at needle exchange sites (known as rapid access to medication).
- DVHA, through the Blueprint, have developed a study design in close partnership with the Department of Corrections (DOC) to evaluate continuity of MAT care for people returning to the community after incarceration. The memorandum of understanding that builds on the previous data sharing agreement between DVHA and DOC has been approved.

Figure 3: Spoke Growth Chart

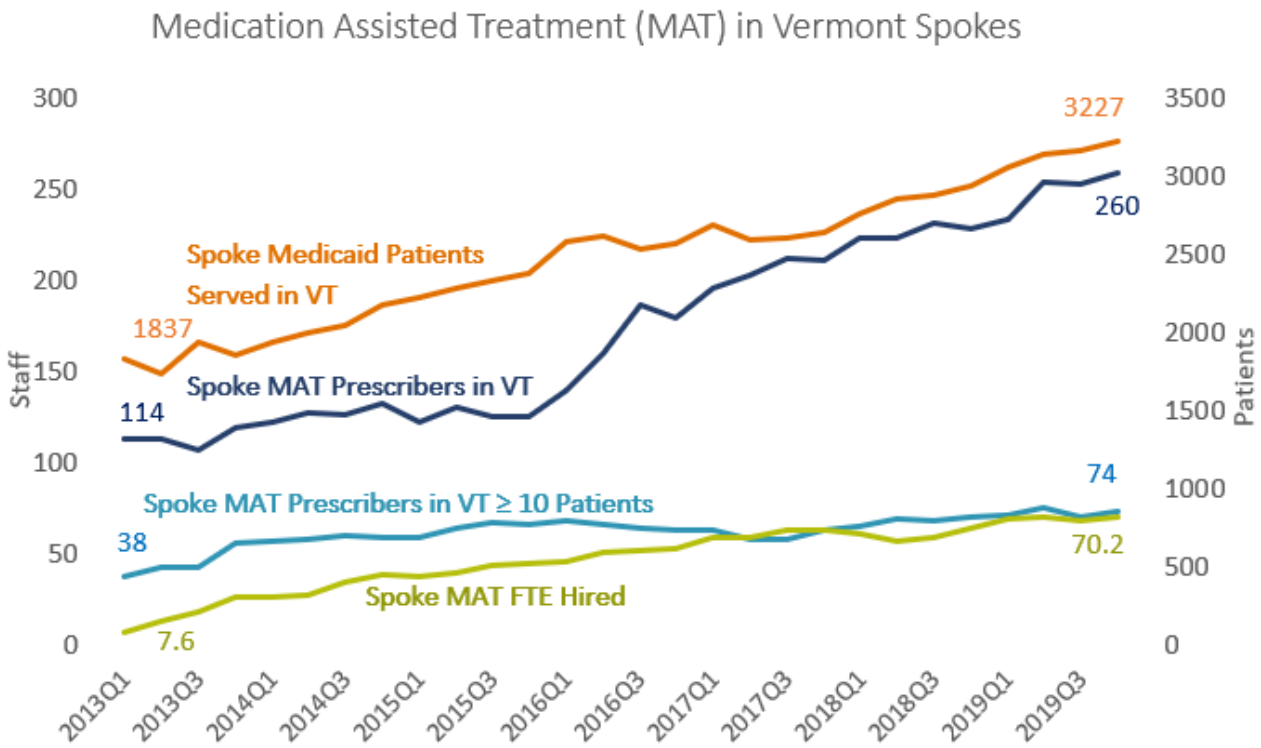
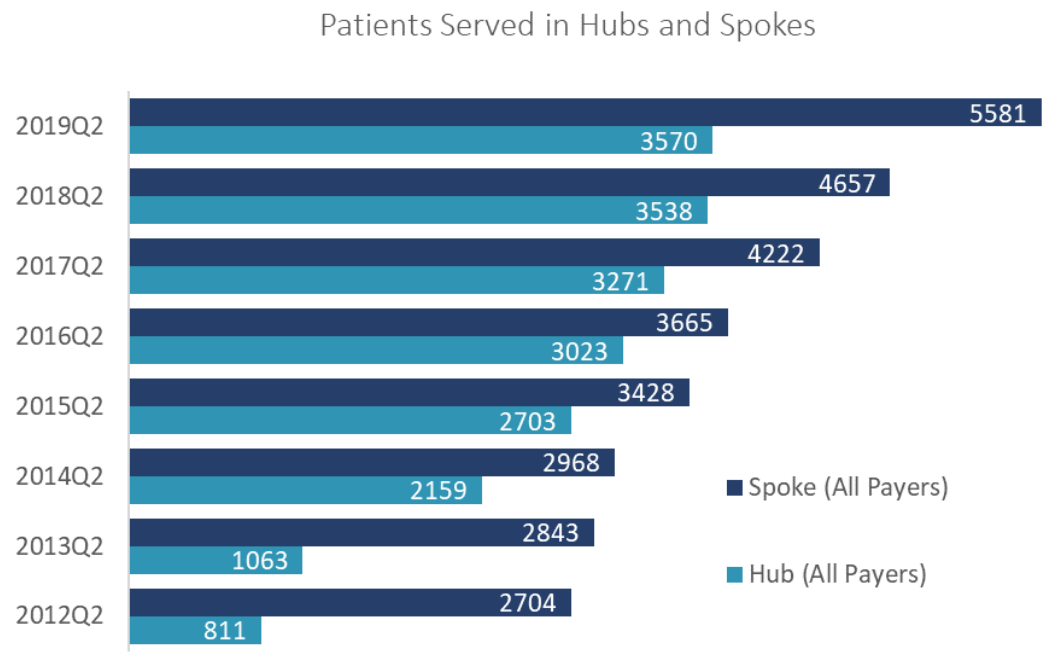


Figure 4 below shows the total number of Vermonters receiving medication assisted treatment in either a Hub or a Spoke over time and for all payers.

Figure 4: Patients Served in Hubs and Spokes All Payers



Source: Vermont Department of Health Hub surveys and Vermont Prescription Monitoring System data

5.5 SELF-MANAGEMENT PROGRAMS

5.5.1 About the Self-Management Programs

The Blueprint offers workshops that help people learn skills to better manage chronic conditions. Topics include healthy living with diabetes, diabetes prevention, tobacco cessation, mental health and emotional well-being, and living with chronic pain. Participants gain a better understanding of their health condition, explore their motivations, identify their strengths, and develop plans for achieving their health goals. They begin putting those plans into action with support from coaches and peers. The workshops last from four weeks to 12 months.

Currently, three organizations support the programs. The Blueprint Program Managers and Self-Management Program Coordinators organize local workshops. Community Health Improvement at the University of Vermont Medical Center offers statewide technical assistance and data collection. Lastly, the Vermont Department of Health supports the training of program leaders and marketing to potential participants.

5.5.2 Self-Management Programs in 2019

In 2019, 733 Vermonters participated in 157 self-management workshops. Table 1 gives the number of each type of workshop held, number of registrants, participants, and completers.

Table 1: Self-Management Programs

Self-Management Programs
October 1, 2018 – September 30, 2019

Workshop Type	Workshops	Registrants	Participants*	Completers**
Chronic Disease	11	115	98	78
Chronic Pain	10	89	79	67
Diabetes	21	228	200	151
Diabetes Prevention	30	314	303	181
Wellness Recovery Action Planning	7	78	53	45
Tobacco	78	298	274	216
Total	**157**	**824**	**733**	**522**

** Participated in one or more session(s)*
*** Completed most of the sessions*

In order to continue to offer Vermonters the most up-to-date, evidence-based interventions, the Blueprint team is examining ways to evolve the Self-Management Programs. Over the past few years, the Blueprint has heard from the field that the current administration of these programs and some of the offerings themselves are no longer achieving the same results as they did in the early years of the program. Also, the number of participants has declined over time. Finding and maintaining workshop leaders is often difficult. Some providers are reluctant to refer to workshops with no set start date (many workshops only run when a threshold of participants is reached). Furthermore, the Blueprint has received feedback that many individuals are more interested in individual offerings and one-on-one coaching approaches to improving health. Because transportation, childcare, and work schedules are often barriers to participation in group workshops, several communities have expressed interest in online or web-based patient-engagement strategies.

To begin evolving the programs, the Blueprint established new requirements for Health Service Areas for the 2019-2020 grant cycle, intended to make this grant year's offerings more effective and to spur innovation.

5.5.3 New Self-Management Programs focus areas for this grant year

During the 2019–2020 HSA Grant Agreement cycle, the Blueprint updated its requirements for the 13 HSAs and their administration of the SMP. These changes included:

- Reducing the number of required workshops to allow Regional Coordinators to focus on the quality of the workshops;
- Requiring the communities to focus on two issues, diabetes and tobacco cessation; and
- Requiring the Regional Coordinators to plan and implement one innovative project that furthers the goal of patient engagement and activation.

5.5.4 Reimagining the Self-Management Programs for the long term

The changes to the Self-Management program for the current grant cycle are just the beginning. As discussed in "The Blueprint in 2019," The Blueprint is currently working with partners at OneCare Vermont, RiseVT, and the Vermont Department of Health in a redesign process that will include collecting input from stakeholders, engaging patients to understand their needs and ideas, considering national best practices in patient education and engagement, and ultimately reimagining the self-management offerings. In addition to developing new education experiences for patients, the planning team may choose to move administration of the self-management programs from the Blueprint to OneCare Vermont.

6 BLUEPRINT EVALUATION – FROM A PROGRAM TO SYSTEM PERSPECTIVE

CONTEXT

Consistent with last year's Annual Report, this evaluation reports on the health service expenditures, utilization, and quality indicators for all Vermonters, regardless of primary care attribution, who are enrolled in a health plan reporting to the Vermont Health Care Uniform Reporting and Evaluation System (VHCURES), Vermont's all-payer claims database. In 2018, this data represented 426,633 people or 68.1% of Vermont's 2018 population. It also looks at subpopulations including those in Blueprint supported initiatives, such as Patient-Centered Medical Homes and Community Health Teams, the Hub and Spoke system of care, and the Women's Health Initiative. Expanding the scope of the evaluation recognizes the maturation of the Blueprint program and its role as one element of a broader set of health care reforms, which include the Green Mountain Care Board's regulatory role and the shift to ACO-based reform through the Vermont All-Payer ACO Model Agreement (the Agreement) with the Centers for Medicare and Medicaid Services (CMS).

To reflect the integrated and synergistic elements of health care reform, this evaluation seeks to 1) understand the trends in health care expenditures and utilization between 2013 and 2018 for the VHCURES population and subpopulations; and 2) identify areas where Blueprint working with key collaborators can support improved care coordination, care management, and preventive care could have impacts.

How Blueprint Evaluation Differs from All-Payer ACO Model Evaluations

Of note, this evaluation is focused on providing information to inform the direction of statewide and local Blueprint leaders and is not an evaluation of the All-Payer ACO Model Agreement. Those evaluations and reports are conducted by the Green Mountain Care Board.[3] Rather, this report aligns the Blueprint evaluation with state priorities and targets established in the Agreement. Specifically, the four overarching priorities of the Agreement are 1) limiting annual growth in expenditures for included services to 3.5% over the life of the agreement; 2) improving access to primary care, 3) reducing prevalence and morbidity of chronic conditions, specifically chronic obstructive pulmonary disorder (COPD), diabetes, and hypertension; and 4) reducing deaths due to suicide and drug overdoses. This report uses related claims and clinical-based measures to assess opportunities for Blueprint's collaboration with OneCare Vermont, Vermont Department of Health, payers, regional communities, and other stakeholders in efforts to support state priorities. An example of a potential opportunity for collaboration is identifying and reducing the rate of potentially avoidable utilization. Table 2 below outlines additional distinctions between reports focused on the Agreement and the 2019 Blueprint for Health Annual Report.

[3] GMCB reports on the All-Payer ACO Model are available at: https://gmcboard.vermont.gov/payment-reform/APM

Table 2: ACO Model Evaluation and Blueprint Annual Report Comparison

All-Payer ACO Model Goals	All-Payer ACO Model Evaluation Parameters and Data Sources	Blueprint Annual Report 2019 Related Measures and Data Sources
Annual growth in per member expenditures ≤ 3.5%	• Medicare Part A & B Services; Commercial and Medicaid acute inpatient and outpatient care, post-acute care, professional services, and durable medical equipment • Data Source: All-payer claims data; bundled and capitated payments	• All health care expenditures reported as claims (including pharmacy and other Medicaid services) • Data Source: All-payer claims; bundled and capitated payments adjusted for inflation
Increased access to primary care	• Self-reported identification of personal health care provider • Data Source: Behavioral Risk Factor Surveillance Survey (BRFSS)	• Claims-based attribution to a primary care provider; utilization of primary care. (Note: claims-based utilization is not a measure of access, but rather a measure of how insured Vermonters interact with their primary care providers) • Data Source: All-payer claims data
Limit increases in prevalence of target chronic conditions (COPD, diabetes, hypertension)	• Self-report history of diagnosis • Data Source: BRFSS Survey	• Claims-based diagnostic coding for conditions • Control of conditions • Data Source: All-payer claims data, Vermont Clinical Registry data
Reduce deaths from suicide & overdose	• Annual rates • Data Source: Vital Statistics	• Claims-based quality measures of mental health care coordination and substance use disorder treatment • Health service utilization and expenditures for Medicaid enrollees with opioid-use disorder • Data Source: All-payer claims data

*Excludes all self-insured plans from all years who no longer reported claims data in 2017 for consistency across years.

LIMITATIONS OF VHCURES AND IMPACT OF *GOBEILLE VS. LIBERTY MUTUAL INSURANCE COMPANY*

As in the previous Annual Report, 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 ERISA 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 (PMPY) 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 in 2017 and 2018 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 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 analysis represents the majority of Vermont residents, from 397,932 (63.5%) in 2013 and 426,633 (68.1%) in 2018.

EVALUATION POPULATIONS

This evaluation includes all individuals represented in the VHCURES claims data after removal of people in self-insured plans no longer reporting in 2017. Trends on key measures are reported for the following populations:

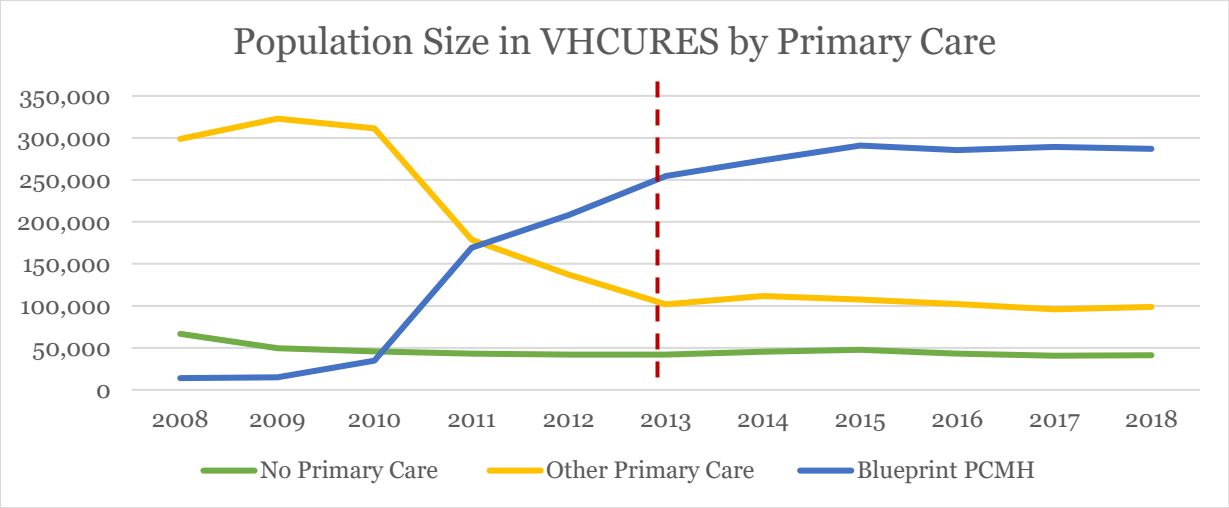
1. **VHCURES Population**: all individuals age one and older enrolled in a health plan contributing data to VHCURES. Years 2013 through 2016 exclude those individuals with plans no longer reporting to VHCURES following the *Gobeille* decision;
2. Primary care attributed[4] groups
    a. **Blueprint PCMH**: Vermonters receiving most of their care in a patient-centered medical home (PCMH);
    b. **Other Primary Care**: Vermonters receiving most of their primary care in a setting other than a Blueprint PCMH;
    c. **No Primary Care**: Vermonters who did not have a primary care visit;
3. Primary payer attribution
    a. **Medicaid**: Vermonters for whom Medicaid was the primary payer;
    b. **Medicare**: Vermonters for whom Medicare or Medicare Advantage was their primary payer[5]
    c. **Commercial**: Vermonters under 65 for whom a commercial insurance plan with medical benefits was their primary payer.
4. Vermonters with opioid use disorder (OUD);
    a. **OUD MAT:** Those Medicaid enrollees receiving medication-assisted treatment (MAT) and participating in the Hub & Spoke program after 2013;
    b. **Other OUD Tx**: Those Medicaid enrollees receiving non-MAT forms of treatment (Tx) for opioid use disorder; and
5. Vermont **women ages 15-44.**

Figure 5 shows the number of Vermonters in each primary care attribution group over time as practices joined the Blueprint and became recognized as PCMHs. As expected, the number of Vermonters receiving primary care in a Blueprint PCMH increases over time with the program's expansion from pilot to statewide. Based on these numbers, we have focused our analysis on the

[4] Attribution is based on qualifying primary care services received over the prior 24 months; see Blueprint for Health website for attribution algorithm.
[5] In this report, those with Medicare Advantage as the primary payer are grouped with the Medicare population; in the All-Payer ACO Model Total Cost of Care calculation, those with Medicare Advantage are grouped with those for whom commercial insurance is a primary payer.

period 2013 to 2018 since 2013 is the year the Blueprint was tasked in statute to have statewide implementation and include all willing providers. It is also the point at which both the Blueprint PCMH and Other Primary Care groups become more consistent in their sizes, thereby reducing the impact of patients crossing from one group to another. See red dashed line in **Error! Reference source not found.**.

Figure 5: Scaling of Blueprint Program and Trends in Population Attribution



Characteristics of VHCURES Population and Subpopulations

Table 2 shows the number, average age, and gender of the overall population, and subpopulations of interest in the VHCURES data between 2011 and 2017. Trends observed in the data include:

- After excluding the non-reporting self-insured populations, VHCURES included data for 7.2% more individuals in 2018 than in 2013. While not shown in the table, the biggest increase occurred between 2013 and 2015.
- During the evaluation period, the overall population represented in the VHCURES data shows a modest increase in the average age. The Blueprint PCMH had the biggest increase in average age. However, the Other Primary Care group continued to have the highest average age and the No Primary Care group the lowest.
- The VHCURES population saw increases in the percent with Medicaid and Medicare coverage, but decreases in the percent with commercial insurance. This pattern was also seen in the Blueprint PCMH and the No Primary Care groups, with the former having a bigger increase in the proportion with Medicare (bringing it almost equal with the Other Primary Care group) and the latter having the bigger increase in the proportion with Medicaid.
- The dramatic increase in the average number of those with an OUD receiving MAT and decline in the average number receiving other non-MAT OUD treatment is primarily due to the expansion of access to MAT through implementation and growth in the Hub & Spoke program.

Table 2: Population Characteristics and Changes Over Time

Demographics	**VHCURES Pop.**	**BP PCMH**	**Other PC**	**No PC**	**OUD MAT**	**OUD Other Tx**	**Women 15-44**
2013 Total	397,932	254,362	101,791	41,779	3,873	1,082	70,908
2018 Total	426,633	286,844	98,571	41,219	7,149	637	74,573
% Change	*7.2%*	*12.8%*	*-3.2%*	*-1.3%*	*84.6%*	*-41.1%*	*5.2%*
2013 Avg. Age	42	41	45	40	33	32	29
2018 Avg. Age	43	43	45	41	36	36	30
% Change	*2.4%*	*4.9%*	*0.0%*	*2.5%*	*8.1%*	*13.5%*	*0.7%*
2013 % Female	52.8%	54.1%	55.9%	37.3%	57.6%	49.1%	n/a
2018 % Female	52.8%	54.3%	54.5%	38.2%	51.0%	50.3%	n/a
% Change	*0.0%*	*0.3%*	*-2.5%*	*2.6%*	*-11.4%*	*2.5%*	*n/a*
2013 % Medicaid	28.4%	30.7%	24.2%	24.5%	86.6%	88.8%	38.9%
2018 % Medicaid	30.4%	31.6%	27.6%	29.1%	90.1%	85.5%	43.3%
% Change	*7.3%*	*3.0%*	*14.2%*	*18.7%*	*4.0%*	*-3.8%*	*11.2%*
2013 % Medicare	26.0%	25.2%	30.9%	19.4%	13.4%	11.2%	3.7%
2018 % Medicare	28.8%	29.5%	30.8%	19.5%	9.9%	14.5%	3.1%
% Change	*10.8%*	*17.1%*	*-0.1%*	*0.6%*	*-26.0%*	*30.0%*	*-14.5%*
2013 % Commercial	45.6%	44.2%	45.0%	56.2%	n/a	n/a	57.4%
2018 % Commercial	40.8%	39.0%	41.6%	51.5%	n/a	n/a	53.6%
% Change	*-10.7%*	*-11.8%*	*-7.6%*	*-8.4%*	*n/a*	*n/a*	*-6.7%*

VHCURES Pop = Vermonters with health care enrollment in VHCURES; BP PCMH = Vermonters attributed to a Blueprint PCMH; Other PC = Vermonters attributed to primary care provider other than a BP PCMH; No PC = Vermonters not attributed to any primary care provider; MAT = Vermonters under 65 enrolled in Medicaid or who are dually eligible for Medicaid and Medicare who receive medication-assisted treatment for opioid use disorder (OUD); and Other OUD Tx = Vermonters under 65 enrolled in Medicaid or who are dually eligible for Medicaid and Medicare who receive substance use disorder treatment (Tx) other than MAT.

Health Status: Primary Care Groups

To understand how the health status of Vermonters has changed between 2013 and 2018, the VHCURES and sub-populations have been stratified by clinical risk groups (CRGs). [6] The clinical risk group system uses diagnoses and interventions to categorize the population into five groups. Table 3 below shows the health status profile of each population and any changes seen over time. Trends observed in the data include:

- While the "Healthy" group remains the group with the highest proportion of the population with data in VHCURES, over time the percentages in this category and the

[6] Blueprint's analytic vendor uses the 3M™ Clinical Risk Groupers (CRGs) to assign health status to individuals. These CRGs use inpatient and ambulatory diagnosis and procedure codes, pharmaceutical data and functional health status to assign each individual to a single, severity-adjusted groups. These groupings are then rolled up to five major categories: Healthy, Acute or Minor Chronic Condition, Moderate Chronic Condition, Significant Chronic Conditions, and Cancer or Catastrophic Conditions. Of note, those with no claims in a year are designated as healthy. For additional examples of which conditions fall into these categories, see the Blueprint Community Profile Supporting Documentation.

"Acute or Minor Chronic" declined as the proportion in "Moderate", "Significant", and "Cancer or Catastrophic" increased. This trend is consistent with Vermont's aging demographics, but additional analysis is needed to understand if there are opportunities for identification and improved care management for those who may be at risk of increasing chronic conditions (i.e., the rising risk population).

- The Blueprint PMCH group tends to have a sicker population than the Other Primary Care group across all years, with the exception of the Cancer or Catastrophic risk group. This finding may reflect a propensity for people with cancer or catastrophic conditions to receive primary care from their specialty care providers, although additional analysis is needed to confirm this interpretation.
- The No Primary Care group is made up predominately of people who fall into the Healthy risk category; however, it also includes people in higher risk groups. Further analysis on specific diagnoses could identify those who might benefit from routine primary care.

Table 3: Populations by Clinical Risk Groups

Populations by Health Status	**VHCURES Pop.**	**BP PCMH**	**Other PC**	**No PC**	**Women 15-44**
2013 % Healthy	41.7%	37.5%	36.8%	79.0%	47.7%
2018 % Healthy	39.0%	33.7%	37.3%	80.2%	44.1%
% Change	*-6.4%*	*-10.1%*	*1.2%*	*1.4%*	*-7.5%*
2013 % Acute or Minor Chronic	19.7%	21.0%	19.9%	11.3%	26.6%
2018 % Acute or Minor Chronic	19.0%	20.1%	19.6%	9.6%	26.3%
% Change	*-3.8%*	*-4.4%*	*-1.8%*	*-14.9%*	*-1.2%*
2013 % Moderate Chronic	23.0%	24.9%	24.7%	7.3%	19.3%
2018 % Moderate Chronic	24.3%	26.6%	24.6%	7.7%	22.1%
% Change	*5.7%*	*7.0%*	*-0.4%*	*6.5%*	*15.0%*
2013 % Significant Chronic	14.7%	15.7%	17.2%	2.20%	6.0%
2018 % Significant Chronic	16.7%	18.7%	17.1%	2.23%	7.1%
% Change	*14.0%*	*18.9%*	*-0.8%*	*1.4%*	*17.7%*
2013 % Cancer or Catastrophic	0.91%	0.86%	1.4%	0.19%	0.42%
2018 % Cancer or Catastrophic	0.95%	0.87%	1.5%	0.22%	0.40%
% Change	*4.4%*	*1.2%*	*8.9%*	*15.8%*	*-4.8%*

Health Status: Opioid Use Disorder Group

Table 4 shows health status for Medicaid members with an opioid use disorder (OUD) diagnosis, grouped by treatment type. Of note, the OUD MAT group represents those receiving services in the Hub & Spoke program following its implementation in 2013. The health status categories for these groups are slightly different because the diagnosis of an OUD by itself is a serious clinical risk factor. Any additional minor to serious comorbidities (such as mental health or chronic disease) puts individuals with OUD in higher risk categories.

- Both OUD treatment groups have similar proportions falling into each health status group, although. The similar average ages, health status distributions, and payer mix in each group, even as the number in the OUD MAT group nearly doubles between 2013 and 2018 with the Hub & Spoke expansion, supports comparing outcomes of these two groups.

- Both groups have high disease burdens; approximately 40% of each population with an OUD diagnosis also has a comorbidity.

Table 4: Health Status of People with an Opioid Use Disorder Diagnosis

OUD Population by Health Status	**OUD MAT**	**OUD Other Tx**
2013 % OUD, no comorbidities	63.6%	65.2%
2018 % OUD, no comorbidities	62.8%	58.5%
% Change	*-1.3%*	*-10.3%*
2013 % OUD + minor, moderate	32.2%	31.0%
2018 % OUD + minor, moderate	32.1%	34.1%
% Change	*-0.4%*	*10.2%*
2013 % OUD + Sig./Catastrophic	4.2%	3.8%
2018 % OUD + Sig./Catastrophic	5.1%	7.4%
% Change	*22.7%*	*93.7%*

OUD MAT = Vermonters enrolled in Medicaid, or dually eligible for Medicaid and Medicare, categorized as having an OUD diagnosis and have received medication-assisted treatment; OUD Other Tx = Vermonters enrolled in Medicaid, or dually eligible for Medicaid and Medicare, categorized as having an OUD diagnosis and receiving other non-MAT forms of treatment (Tx).

Prevalence of Chronic Conditions: COPD, Diabetes, and Hypertension

The state's All-Payer ACO Model reports will use self-reported BRFSS adult data to assess whether the prevalence of each chronic condition (COPD, diabetes, and hypertension) has increased from 2016 to 2022 by one percentage point or less.[7] This report uses annual claims data to calculate prevalence rates across the VHCURES population, including pediatrics, and subpopulations. Table 6 displays the proportions (or prevalence) in the VHCURES and sub-populations of those who have the disease diagnosis listed in their claims data according to HEDIS specifications. The prevalence rates for the key conditions are listed for both 2013 and 2018 as are the compounded annual growth rates between these two years. While claims-based prevalence is not the metric used to assess the All-Payer ACO Model, this data can be used as an indicator to help identify whether programmatic or care delivery changes are needed to meet the Agreement targets. For example, using 2016 as the base year, the projected increase in the prevalence of those with hypertension is greater than 1 percentage point by 2022. This finding regarding hypertension is one of the considerations informing the re-imagining of the self-management programs through the Blueprint's collaboration with Vermont Department of Health, OneCare Vermont, and RiseVT.

Regarding the subpopulation groups:

- The Blueprint PCMH group had the highest prevalence in all conditions and higher or similar annual growth rates. Using the claims-based estimated prevalence for 2016, the Agreement's baseline, these growth rates project that the Blueprint PCMH group will see

[7] For example, the 2016 prevalence of COPD reported in by BRFSS was 6%. Under the Agreement, Vermont is seeking to keep prevalence under 7% by 2022. The 2016 prevalence of diabetes reported in BRFSS was 8%; therefore, the target 9% or less. Hypertension's prevalence in 2017 was 26% (2016 not reported, so the target would be 27% or less.

the prevalence for each of the conditions increase by more than 1 percentage point by 2022. While the growth rates could result in part from a shift in the Blueprint PCMH demographics, such as its increase in average age, they could also indicate an opportunity to improve earlier identification of those at risk for these conditions and enhance population health approaches to healthier living.

- Not unexpectedly, as these conditions are often age-associated, the Medicare group has the highest prevalence in each condition.

Table 5: Prevalence of COPD, Diabetes, and Hypertension Among Populations of Interest

	COPD			***Diabetes***			***Hypertension***		
	2013 Prev.	2018 Prev.	Annual Growth	2013 Prev.	2018 Prev.	Annual Growth	2013 Prev.	2018 Prev.	Annual Growth
VHCURES Pop.	3.3%	3.8%	*2.9%*	7.6%	8.2%	*1.4%*	20.1%	21.2%	*1.0%*
BP PCMH	3.5%	4.3%	*4.3%*	8.2%	9.2%	*2.2%*	22.0%	24.1%	*1.9%*
Other Primary Care	4.0%	3.8%	*-1.2%*	8.8%	8.2%	*-1.5%*	22.7%	20.7%	*-1.8%*
No Primary Care	0.4%	0.5%	*3.5%*	1.3%	1.5%	*2.8%*	2.6%	2.2%	*-3.9%*
Medicaid	1.4%	1.8%	*4.1%*	3.2%	3.5%	*1.5%*	6.7%	6.9%	*0.4%*
Medicare	10.2%	10.5%	*0.6%*	19.6%	19.2%	*-0.4%*	51.2%	50.7%	*-0.2%*
Commercial	0.6%	0.7%	*3.7%*	3.5%	3.9%	*2.0%*	10.7%	11.0%	*0.5%*
H&S MAT	3.7%	5.2%	*6.9%*	3.9%	4.5%	*2.8%*	9.6%	11.4%	*3.5%*
Other OUD Tx	2.6%	6.9%	*21.2%*	3.5%	6.9%	*14.3%*	9.7%	17.3%	*12.2%*
Women 15-44	0.4%	0.4%	*-0.5%*	2.2%	2.2%	*-0.1%*	3.4%	3.2%	*-1.1%*

Clinical and Claims Data – Increasing Understanding of Chronic Conditions Through Linkage

Analyses that combine claims and clinical data provide richer insights into the relationship between services, risk factors, and health outcomes. The linked data can answer questions such as: "Are the annual expenditures for people with well-controlled hypertension different from those whose blood pressure is not under control?" and, "Is there an association between utilization of primary care and hypertension in control?" To date, the limiting factor in these measures has been the completeness of the clinical data due to gaps in data submissions and quality. While the Blueprint and the state have put significant resources into aggregating clinical data gaps in data availability remain; therefore, a significant drop exists between the number of people identified in claims with the diagnosis and the number that are linked to useable clinical measurements. For example, in the VHCURES population, we identified 90,345 individuals with a hypertension diagnosis. However, only 52,135 of those had a blood pressure reading in the Vermont Clinical Registry. Of note, the Blueprint PCMH group has the smallest drop between the number with a diagnosis in claims and the number linked to clinical data, which likely reflects the intense work with PCMHs to connect their electronic health records to the Vermont Health Information Exchange.

While more complete data is needed, the data currently available does provide insights.

- While the majority of people with linked clinical data have their hypertension in control (approximately 66%), fully one third (34%) do not, which, given the high prevalence of hypertension, accounts for a substantial number of individuals.
- The Blueprint PCMH population appears to have slightly better control of diabetes; however, the low percentage with linked clinical data for each of the primary care groups increases the uncertainty in those proportions.
- Control of hypertension and diabetes appears to be lower for Medicaid members than for other insurer groups.

Table 6: Control of Chronic Conditions - Power of Linked Claims and Clinical Data

	Hypertension (HTN): Blood Pressure in Control			***HbA1c Poor Control (>9%)***		
	2018 N Linked	2018 % Linked	2018, % HTN in Control	2018 N Linked	2018 % Linked	2018, % Poor Diabetes Control
VHCURES Pop.	52,135	57.7%	66%	12,342	35.3%	14%
Blueprint PCMH	44,246	64.0%	66%	10,348	39.4%	14%
Other Primary Care	7,646	37.6%	67%	1,831	22.8%	15%
No Primary Care	243	27.3%	61%	163	26.5%	23%
Medicaid	5,740	64.5%	62%	2,001	44.2%	24%
Medicare	34,080	54.7%	66%	6,933	29.4%	11%
Commercial	12,315	64.4%	66%	3,408	50.4%	15%
OUD MAT	519	63.8%	58%	123	1.6%	31%
Other OUD Tx	68	61.8%	63%	26	3.7%	*
Women 15-44	1,603	67.1%	68%	715	42.9%	21%

*Numerator less than 11, so information blinded.

EXPENDITURES

VHCURES Population Expenditures 2011-2017

The All-Payer ACO Model Agreement sets 3.5% annual growth for included services as the expenditure target over the life of the agreement. The below analysis aligns with the Green Mountain Care Board's methodology for the All-Payer ACO Model's total cost of care calculation to a large degree, but differs in that it includes services beyond those identified in the Agreement, such as retail pharmacy and Medicaid-covered mental health and substance abuse disorder treatment services. This expenditure analysis, similar to the All-Payer ACO Model Total Cost of Care calculation[8], also differs from the Green Mountain Care Board's Vermont Health Care Expenditure Analysis (VHCEA) in that it is limited to claims allowed amounts available for the VHCURES population and non-claim payments related to direct medical care such as care

[8] A summary of how the All-Payer ACO Model Total Cost of Care calculations differ from the Vermont Health Care Expenditure Analysis is available on slide four at: https://gmcboard.vermont.gov/sites/gmcb/files/2017_Expenditure_Analysis_with_projections_March_27_2019.pdf

management and capitation. This analysis also adjusts all expenditures between 2013 and 2018 for inflation.[9]

Of note, the expansion of value-based payments has introduced a layer of complexity to calculating per member per year expenditures. Future consideration will need to be given to evolving the evaluation methodologies to accommodate non-fee-for-service payments. Vermont Medicaid's capitated payments to OneCare Vermont through the Vermont Medicaid Next Generation (VMNG) contract covered all services identified in the contract, including those in traditional service categories, such as outpatient, inpatient and professional services. While Medicaid claims data allow for analysis of utilization rates for services covered by the capitated payment, they do not assign actual dollar amounts specific to those services. Therefore, throughout the report, the VMNG capitated payments are presented as a total amount and not by separate categories of service, while the VMNG fee-for-service payments in OneCare Vermont's value-based arrangement are included in specific service categories. Further, calculations do not include funds retained by OneCare or repaid to the State as a result of the risk sharing arrangement for the VMNG program.

Medicare's capitated payments (a.k.a., all-inclusive population-based payments), on the other hand, recorded which services these payments went toward, allowing those capitated payments to be assigned to a service category. The final category that is listed separately is the Medicare Shared Savings, which was a portion of the Medicare payments retained by OneCare Vermont after Medicare expenditures for attributed Medicare beneficiaries were less than projected. Both the Green Mountain Care Board and the Blueprint are including these expenditures as part of the total cost of care.

The primary goal of reporting expenditures in this evaluation is to provide a perspective on person-level expenditures and to consider how this information can inform program decisions. Table 7 reviews how expenditures by categories of service changed over time. While some of the spending categories are specific to certain sub-populations, for example Blueprint payments apply to only those attributed to Blueprint PCMHs, Spokes, and Women's Health Initiative Practices, the amounts were averaged across the VHCURES population to reflect the relative distribution of expenditure streams. Of note, the pharmacy category does not factor in rebates received by Medicaid and commercial payers, so overall does not reflect net expenditures.

- In 2018, following financial reconciliation, OneCare's expenditures for its Medicare-attributed population were less than anticipated, resulting in $5.6 million in Medicare shared savings.
- In 2017, following financial reconciliation, OneCare's expenditures for its Medicaid-attributed population were less than anticipated, resulting in the ACO retaining $2.4 million. In 2018, OneCare's expenditures for its Medicaid-attributed population were more than anticipated, resulting in $1.5 million in repayments to the State.
- Overall annual growth across all expenditure categories *per person* is 2.8%, which includes adjustments for inflation.

[9] Inflation adjustment factor is based on Gross Domestic Product data from the Federal Reserve Economic Data.

- Inpatient expenditures had the smallest annual growth of all categories while outpatient and pharmacy had the highest.

Table 7: Unadjusted Total PMPY Expenditures for VCHURES Population by Category

Unadjusted Expenditures by Category	***2013 PMPY***	***2018 PMPY***	***Annual Growth***
Inpatient – Facilities	$1,749	$1,776	0.3%
Outpatient – Facilities	$1,897	$2,220	3.2%
Professional	$1,455	$1,485	0.4%
Pharmacy	$1,257	$1,606	5.0%
Other†	$334	$386	2.9%
*SMS^*	$759	$889	3.2%
*Blueprint Payments**	$52	$73	6.9%
VMNG Capitated ᵅ	$0	$168	n/a
Medicare Shared Savings	$0	$13	n/a
Total	$7,502	$8,617	2.8%

*Growth in Blueprint payment as a proportion of the PMPY also reflects the increase in individuals attributed to the program.
† "Other" category includes services such as hospice, home health, durable medical equipment, dental, pharmaceuticals in medical claims, and unclassified.
^"SMS" or Special Medicaid Services includes residential care, day treatment, school-based services, dental services, transportation, and care management.
ᵅ VMNG Capitated = Vermont Medicaid Next Generation capitated payments to OneCare Vermont. Fee-for-service payments made through OneCare's value-based arrangement are included in the relevant service categories. Neither capitated or fee-for-services payments made through the OneCare value-based arrangment have been adjusted to reflect the end of the year reconcilliation that results from the risk-sharing arrangement in the VMNG program.

Expenditures by Clinical Risk Groups (CRG)

Examination of expenditures by health status found unsurprisingly that those categorized in the "Significant Chronic" and the "Cancer or Catastrophic" groups had the highest PMPY expenditures, making up 45.5% and 10.0% respectively of total expenditures in 2018. However, while focusing on the sickest portion of our population will continue to be a priority, Table 8 indicates a need to address expenditures across all risk categories.

- The Healthy, Minor Chronic or Acute, and Moderate Chronic made up 45% of 2018 expenditures, but these groups had the highest growth rates over time and account for the largest proportion of the population, 82.3%.
- While we anticipate some expenditure growth in these lower risk groups as the system emphasizes primary and preventive care, it is worth exploring whether the below information, when paired with potentially avoidable hospital use, indicates an opportunity to address rising risk and potentially avoidable health care use across all risk groups.

Table 8: Unadjusted Expenditures by Clinical Risk Groups

	2018 % of Population	***2018 % of Total Expenditures***	***2018 PMPY***	***2013-2018 Annual Growth, PMPY***
Healthy	39.0%	6.4%	$1,391	2.3%
Minor Chronic or Acute	19.0%	11.0%	$5,031	1.5%
Moderate Chronic	24.3%	27.1%	$9,552	1.3%
Significant Chronic	16.7%	45.5%	$23,164	1.3%
Cancer or Catastrophic	0.95%	10.0%	$88,071	1.0%

Expenditures for Primary Care Groups

Based on the below figures and table, the Blueprint PCMH group had lower total expenditures but higher growth overtime. Potential contributors to this higher rate of growth could be greater increases in the prevalence of the three target chronic conditions and in greater increases in the proportion of individuals in the higher clinical risk groups than the Other Primary Care group. Of note, Blueprint payments in Table 9 include SASH, Spoke staff, and Women's Health Initiative payments, which could be made on behalf of patients not attributed to a Blueprint PCMH. Therefore, Blueprint payments are present, though to a lesser degree, in the Other Primary Care and No Primary Care groups.

- The unadjusted and risk-adjusted total expenditures for the Blueprint PCMH group were lower than for the Other Primary Care group despite the Blueprint population having higher and increasing proportions with moderate and significant chronic conditions. While the crude annual growth was higher for the Blueprint population (3.1% vs. 1.8%), when adjusted for age, gender, health status, etc., those difference disappeared (1.5% vs. 1.5%).
- Despite greater increases in most categories except Outpatient, the Blueprint PCMH group had lower expenditures than the Other Primary Care group in each category except SMS[10], Blueprint payments, and VMNG capitated payments. Higher expenditures in SMS has been interpreted as positive and an indication that Vermont Medicaid enrollees are receiving more coordinated care and care in more appropriate settings, such as home and community-based services.
- The No Primary Care group had the lowest overall PMPY in each expenditure category. However, this group had higher rates of growth in the Professional and Other categories than the Blueprint PCMH group. In Figure 6a. the No Primary Care group shows an increase in the average PMPY after 2016.
- When total expenditures for each primary care group are adjusted for age, sex, health status, payer, etc. the trends are maintained, and the differences are statistically significant (Figure 6).

[10] SMS = Special Medicaid Services, those services specific to only Vermont's Medicaid program and include residential care, day treatments, school-based services, dental care, transportation, case management, and monthly Hub payments

Figure 6: Total Expenditures by Category for Primary Care Attribution Groups

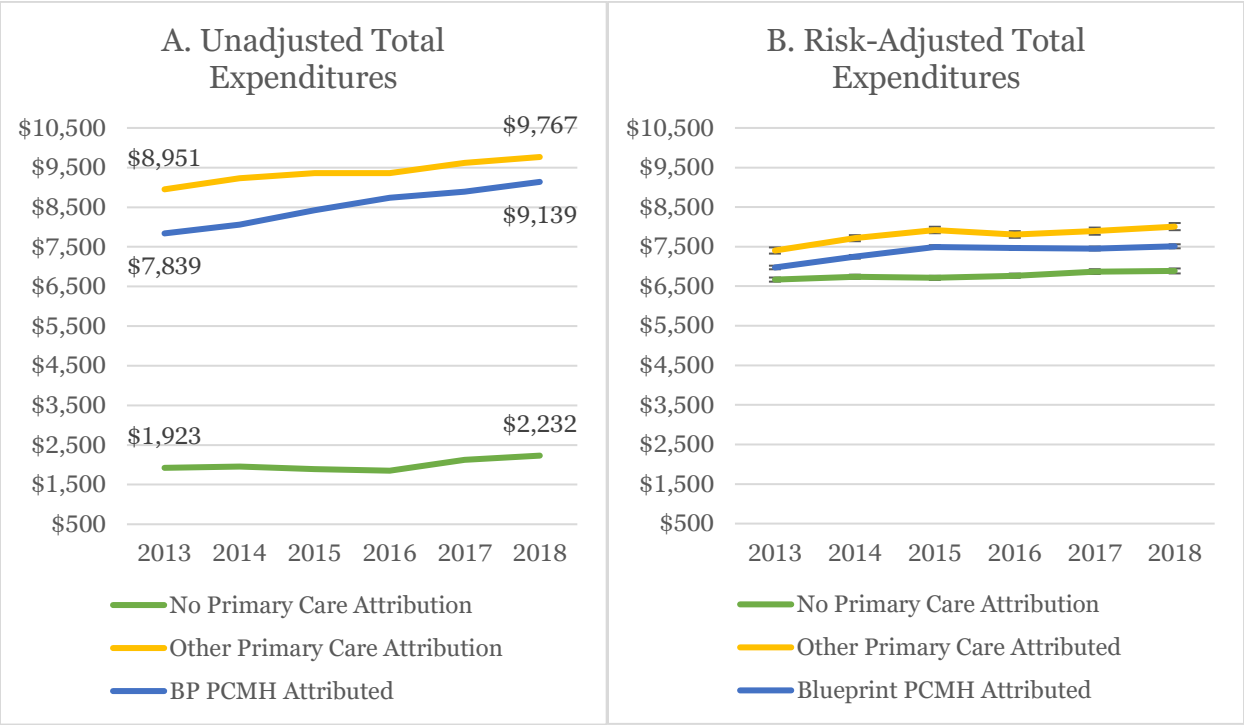


Table 9: Total Expenditures by Category for Primary Care Attribution Groups, Unadjusted

	BP PCMH			*Other Primary Care*			*No Primary Care*		
Category	2018 PMPY	2013-2018 % Change	Annual Growth	2018 PMPY	2013-2018 % Change	Annual Growth	2018 PMPY	2013-2018 % Change	Annual Growth
*Inpatient**	$1,858	6.2%	1.2%	$2,159	-8.2%	-1.7%	$411	-0.5%	-0.1%
*Outpatient**	$2,275	17.0%	3.2%	$2,777	17.4%	3.3%	$506	9.1%	1.8%
Professional	$1,589	3.9%	0.8%	$1,639	-4.5%	-0.9%	$388	9.0%	1.7%
Pharmacy	$1,691	29.7%	5.3%	$1,895	22.2%	4.19%	$328	26.2%	4.8%
Other	$398	21.3%	3.94%	$474	4.0%	0. 8%	$97	32.9%	5.9%
SMS	$1,017	11.9%	2.27%	$698	26.9%	4.9%	$451	29.2%	5.3%
Blueprint	$96	28.0%	5.06%	$29	93.3%	14.1%	$21	133. 3%	18.5%
VMNG Capitated	$204	--	--	$124	--	--	$16	--	--
Total	$9,139	16.6%	3.1%	$9,767	9.1%	1.8%	$2,232	16.1%	3.0%

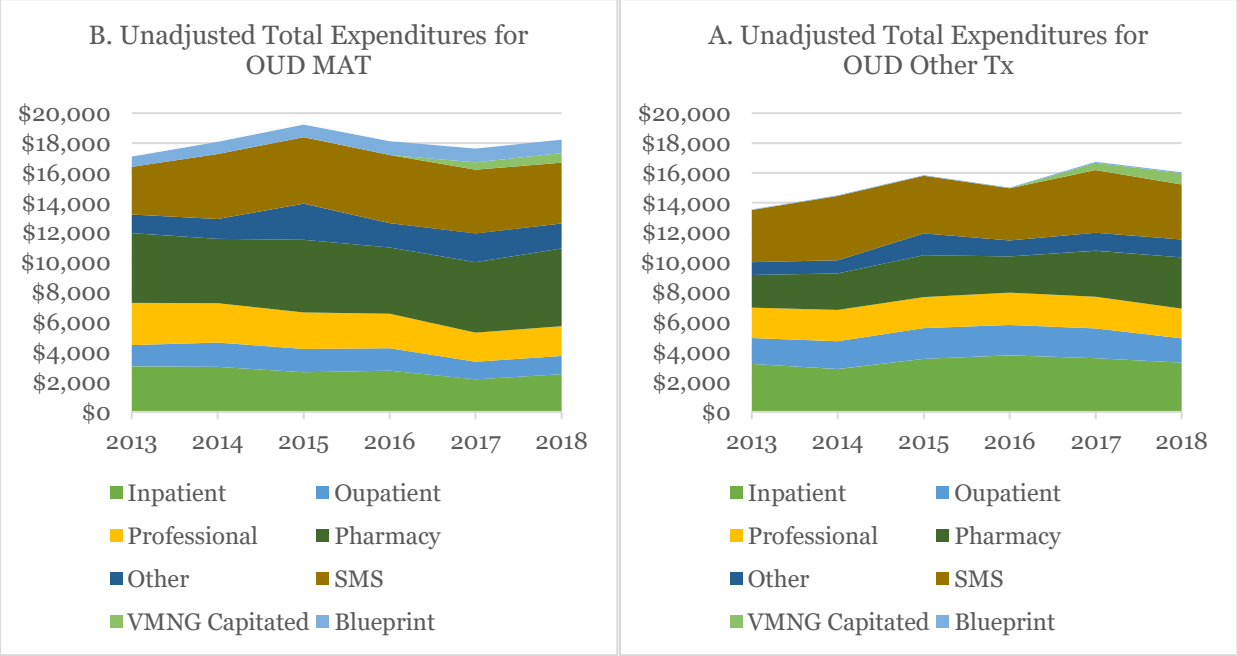
*Facility claims

Expenditures for Opioid Use Disorder Groups

Vermonters with opioid use disorder (OUD) have high PMPY expenditures ($16,000 to $18,200 versus $8,600 for the VHCURES population), which is expected given these groups' high disease burden. When looking at the OUD groups stratified by treatment type, the claims data presents some interesting findings.

- PMPY expenditures for both OUD groups (OUD MAT and OUD Other Treatment (Tx)) remained relatively stable over time, despite almost doubling the number of people receiving MAT between 2013 and 2018 and the additional expenses of Hub & Spoke services (Figure 7).
- Both OUD MAT and OUD Other Treatment had similar total cost of care but different distributions across expenditure categories (Table 11)
    - OUD MAT had lower and declining inpatient, outpatient, and professional expenditures.
    - OUD MAT group has higher proportion of their total expenditures due to pharmacy costs, which include treatment medication such as buprenorphine. However, pharmacy expenditures for the OUD MAT group are increasing at a slower rate over time compared to the trend in pharmacy expenditures for the OUD Other Treatment group.
- A greater proportion of expenditures for the OUD MAT group went toward OUD treatment costs and the group showed reduced expenditures for other medical services relative to the OUD Other Treatment group.
- The spike in 2015 expenditures in the OUD MAT group (Figure 7) include a rapid increase in urinalysis or drug testing. This data does not reflect the impact of a settlement that the state reached with the testing laboratories for more than $5 million in over-billing in 2015. While the cost of urinalysis does not appear to have returned to pre-2013 levels, it has come down significantly since 2015.

Figure 7: Total Expenditures by Category for OUD Populations



*Adjustment model includes non-OUD Medicaid population, thereby drawing the expenditures for the OUD groups closer to the non-OUD Medicaid total expenditures.

Table 10: Total Expenditures by Category and Opioid Use Disorder Treatment, Unadjusted

	OUD MAT			***OUD Other Tx***		
Category	2018 PMPY	2013-2018 % Change	Annual Growth	2018 PMPY	2013-2018 % Change	Annual Growth
Inpatient	$2,517	-17.5%	-3.8%	$3,300	2.5%	0.5%
Outpatient	$1,234	-13.7%	-2.9%	$1,627	-5.2%	-1.1%
Professional	$1,997	-29.3%	-6.7%	$1,980	-2.8%	-0.6%
Pharmacy	$5,185	11.3%	2.2%	$3,444	57.0%	9.4%
Other	$1,677	34.8%	6.2%	$1,185	37.6%	6.6%
SMS	$4,065	27.4%	5.0%	$3,698	5.8%	1.1%
Blueprint	$890	29.4%	5.3%	$71	82.1%	12.7%
VMNG Capitated	$661	--	--	$739	--	--
Total	$18,234	6.7%	1.3%	$16,053	18.4%	3.4%

*Blueprint payments include Spoke payments as well as PCMH, CHT, SASH, and Women's Health Initiative payments

UTILIZATION: OPPORTUNITIES FOR IMPROVED CARE QUALITY AND MANAGEMENT

Utilization of Primary Care

Increasing access to primary care is one of the All-Payer ACO Model Agreement population-level targets as measured by the percent of adult residents who report they have a personal health care provider in the Behavioral Risk Factor Surveillance Survey (BRFSS). This report focuses on the related measures of primary utilization, specifically rate of primary care visits and the proportion with a primary care visit in the measurement year. While related, utilization is not a measure of access to primary care since VHCURES claims data does not assess availability or timeliness of appointments or how those Vermonters whose data is not reported in VHCURES use primary care. Rather this evaluation reports on how the majority of Vermonters with coverage interact with primary care.

First, using the Blueprint attribution method, Figure 8 shows the trends in the number and proportion of Vermonters, older than 1 year, who were attributed to any primary care provider, and of those, the proportion who were attributed to a Blueprint PCMH. Between 2013 and 2018, approximately 90% of Vermonters in VHCURES had primary care claims in the prior 24 months. Of these, approximately three-fourths received the plurality of their primary care at a Blueprint PCMH.

- As a result of the Blueprint program expansion, three-fourths of those receiving primary care in 2018 received it in a Blueprint PCMH.
- The proportion with no primary care records over this period (the No Primary Care group) remained steady at 10%. While nearly 80% of this population is categorized as healthy, the remaining 20% fall into higher risk groups. Further analysis is needed to understand why these individuals are not engaged with primary care.
- While claims data shows primary care utilization increased between 2013 and 2018, it does not tell us whether access is sufficient or convenient.

- The Blueprint PCMH group sees increases for both the rate of visits and the percent of people with a visit in a measurement year, indicating that the higher rate is not simply driven by a small group of high utilizers.
- The OUD MAT group had an increase in the rate of primary care visits in a year while the proportion who had a primary care visit in a year remain consistent over time. The OUD Other Treatment group had increases in both the rate and percent, but both remain substantially below the OUD MAT group. Of note, these numbers may underestimate the interactions of the OUD MAT group with primary care. Often Spoke patients meet with Spoke Staff (the nurse or mental health specialist), and not the prescribing provider. Since Spoke staff encounters do not generate a claim, they are not identified in this claims-based analysis.

Figure 8: Trends in Attribution to Primary Care

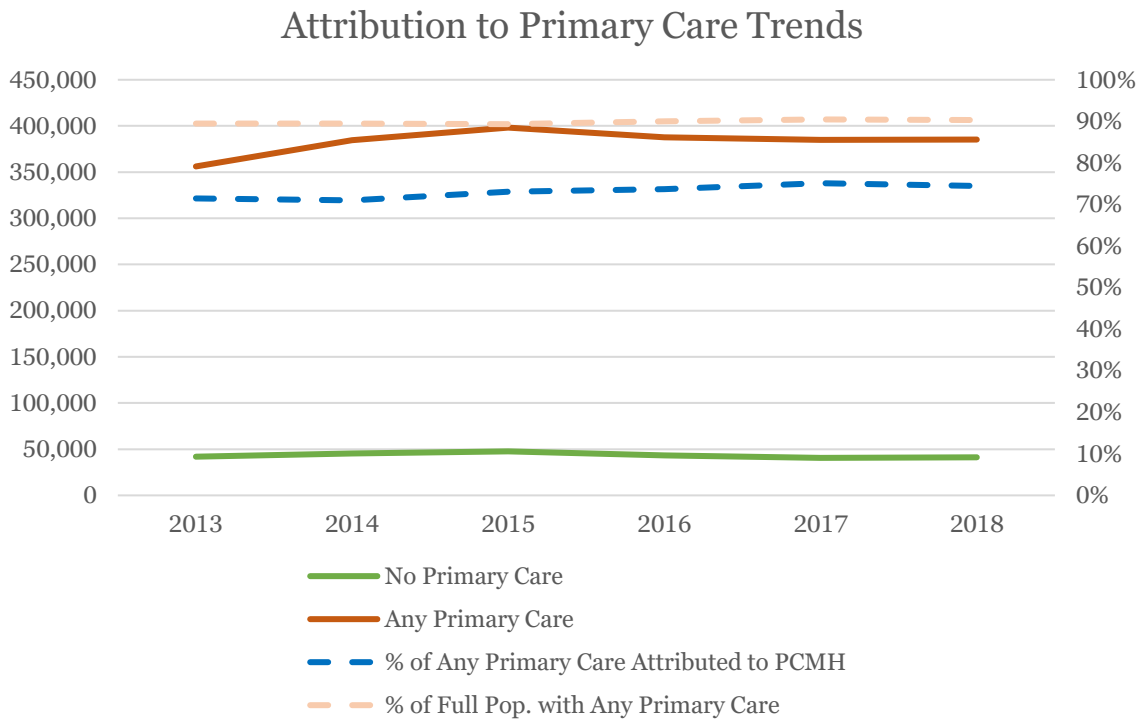


Table 11: Utilization of Primary Care

	PCP Visits/ 1,000 Member Years			% with Primary Care Visit in Year*		
	2013	**2018**	**% Change**	**2013**	**2018**	**% Change**
VHCURES Pop.	2,957	3,077	4.1%	69.3%	71.4%	3.0%
Blueprint PCMH	3,249	3,452	6.2%	79.3%	81.1%	2.4%
Other Primary Care	3,412	3,218	-5.7%	76.4%	76.8%	0.5%
Medicaid	3,564	3,502	-1.7%	72.7%	73.7%	1.3%
Medicare	3,564	3,581	0.5%	69.1%	72.3%	4.5%
Commercial	2,233	2,404	7.7%	67.2%	69.1%	2.9%
OUD MAT	8,235	9,240	6.4%	83.2%	83.2%	0.0%
OUD Other Tx	4,727	4,999	5.8%	75.7%	78.6%	3.8%
Women 15-44	2,924	3,097	5.9%	68.5%	70.0%	2.1%

*Percent with primary care visit within the measurement year differs from percent attributed to primary care, which has a 24-month lookback.

Access Patterns: Adolescent Well Visits

Another view of access to primary care is the percent of adolescents age 12-21 who have a well-care visit. Figure 9 shows the percentage with an adolescent well-care visit by primary care group.

- Both the Blueprint PCMH and Other Primary Care groups saw an increase in well-care visits between 2015 and 2016. In January 2016, the Blueprint program began making performance-based payments, which included adolescent well-care visits, and many communities and PCMHs across the state launched initiatives to improve outcomes for this measure.
- While the Other Primary Care group saw a slight decline in the percentage with an adolescent well-care visit between 2016 and 2017, the percentage increased again in 2018. However, the percentage remains below 50%.

Figure 9: Percent of 12-21-Year-Olds with Adolescent Well Visit, by Primary Care Status

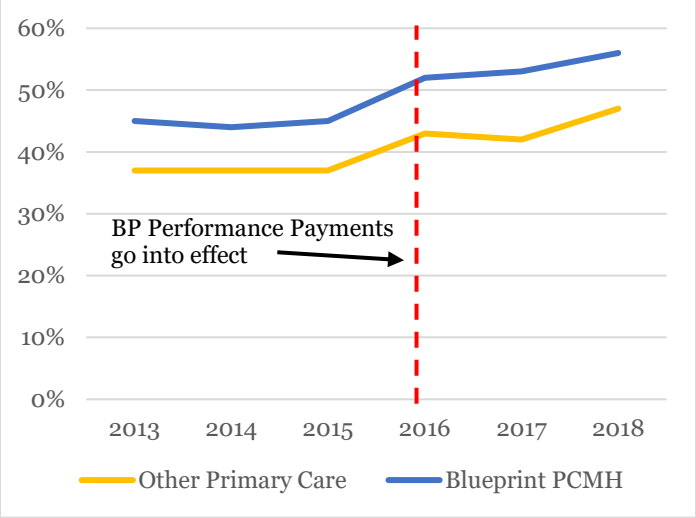


Table 12: Percent of Members Age 12-21 with Adolescent Well-Care Visits

	2018 N Age 12-21	***2018 % w/ Visit***	***% Change from 2013***
VHCURES Pop.	45,678	51%	24.4%
Blueprint PCMH	32,649	56%	24.4%
Other Primary Care	10,430	47%	27.0%
Medicaid	26,164	48%	26.3%
Commercial	19,421	54%	25.6%
Women 15-21	15,427	47%	20.5%

Potentially Avoidable Emergency Department Visits and Inpatient Discharges

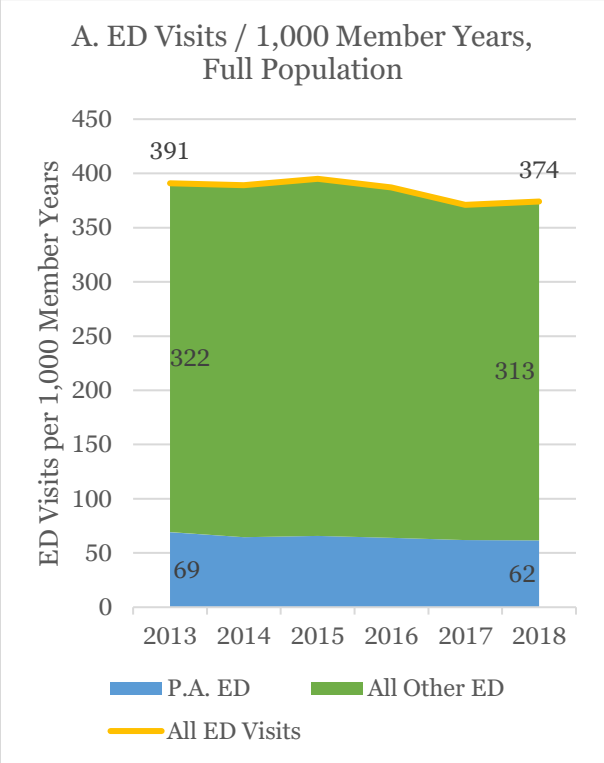
The Blueprint and the state's subsequent health reform initiatives seek to improve health outcomes and reduce the growth in the cost of care by providing timely and appropriate access to care. Reducing inpatient and emergency department (ED) utilization, especially potentially avoidable or unnecessary utilization, have been key targets of care management and quality improvement initiatives. Two indicators of potentially avoidable inpatient use are discharges for ambulatory care sensitive conditions (ACSCs)[11] and readmissions within 30 days of a discharge.

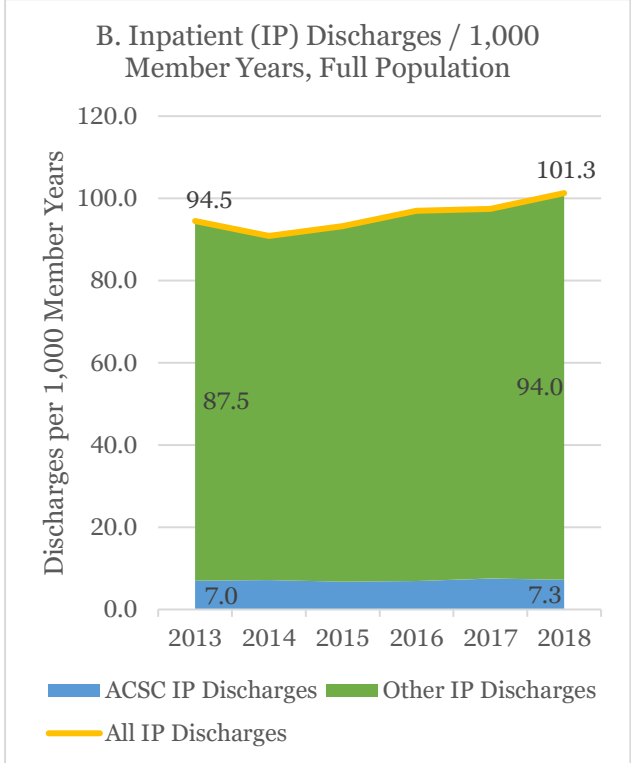
[11] ACSC = Ambulatory Care Sensitive Conditions, AHRQ's Prevention Quality Indicator (PQI) 92 is a composite measure of the following chronic conditions per 100,000 population for ages 18 years and older. In this analysis, however, the denominator for the rate of inpatient discharges for ACSCs is the number of all individuals older than 1 year of age so that the ACSC discharge rate can be compared to the rate for all inpatient discharges. ACSC includes admissions for the following conditions: diabetes with short-term complications, diabetes with long-term complications, uncontrolled diabetes without complications, diabetes with lower-extremity amputation, chronic obstructive pulmonary disease, asthma, hypertension, heart failure, or angina without a cardiac procedure.

ACSCs are conditions that can be well managed on an outpatient basis with guideline-based care. Therefore, rates of ACSC inpatient admissions may indicate opportunities to reduce unnecessary utilization. In this section, we explore whether we see evidence of changing patterns of utilization, specifically whether there are declines in potentially avoidable utilization or care shifting from acute care settings to preventive or routine care settings.

- Except for the Medicare population, all emergency visits not resulting in an inpatient admission declined for the VHCURES and sub-populations. Declines in potentially avoidable ED visit constitute a significant proportion of this decline.
- Although there were fewer ED visits and potentially avoidable ED visits over time, the Blueprint PCMH group had higher rates of both types of visits relative to the Other Primary Care group. These rates also declined more slowly relative to the Other Primary Care. While part of this trend could be attributed to the Blueprint's higher proportions in the high-risk categories, additional analyses at the ACO, practice, or community levels are needed to identify factors driving these trends and appropriate interventions to address them.
- Inpatient discharge rates for the VHCURES population increased due to both ACSCs and other causes. The Blueprint PCMH group had higher rates for all inpatient discharges and ACSC inpatient discharges than the Other Primary Care group. While part of this trend could be attributed to the Blueprint's higher proportions in the high-risk categories, additional analyses at the ACO, practice, or community levels are needed to identify ways to reduce admissions for ACSCs.
- Both OUD groups had much higher utilization than other populations, further supporting the finding that these groups have a much higher disease burden. Yet, the OUD MAT group had approximately a third lower rate in all ED visits, potentially avoidable ED visits, and inpatient discharges than the OUD Other Treatment group, despite demographic and health status similarities.
- All-cause inpatient readmission within 30 days of discharge increased over the period for all populations expect the No Primary Care and Medicare groups. Both OUD treatment groups had the highest rates of readmissions.

Figure 10: Emergency Department Visits, Inpatient Discharges, and Potentially Avoidable Utilization, VHCURES Population





ACSC = Ambulatory Care Sensitive Conditions

Table 13: All and Potentially Avoidable (PA) Emergency Department (ED) Visits per 1,000 Member Years

	2018 All ED Visit Rate	***2018 PA ED Visit Rate***	***% of ED that are PA***	***2013 to 2018 % Change in All ED***	***2013 to 2018 % Change in PA ED***
Blueprint PCMH	409	68	16.6%	-2.9%	-9.3%
Other Primary Care	374	60	16.0%	-9.2%	-15.5%
No Primary Care	132	21	15.9%	-15.9%	-22.2%
Medicaid	536	106	19.8%	-17.8%	-21.5%
Medicare	485	68	14.0%	2.5%	-4.2%
Commercial	175	25	14.3%	-3.8%	-7.4%
OUD MAT	997	144	14.4%	-27.8%	-38.5%
OUD Other Tx	1,412	244	17.3%	-27.9%	-29.7%
Women 15-44	456	84	18.4%	-19.6%	-20.8%

ED = Emergency Department; P.A. = Potentially Avoidable

Table 14: All Inpatient Discharges and Discharges for Ambulatory Care Sensitive Conditions per 1,000 Member Years

	2018 IP Rate	***2018 ACSC IP Rate***	***% 2018 IP due to ACSC***	***2013 to 2018 % Change in All IP***	***2013 to 2018 % Change in ACSC IP***
Blueprint PCMH	107.7	7.8	7.3%	12.5%	6.5%
Other Primary Care	113.6	8.1	7.1%	-3.9%	-6.1%
No Primary Care	27.2	1.4	5.0%	-7.1%	29.0%
Medicaid	76.2	3.5	4.5%	-8.3%	-0.2%
Medicare	217.9	20.5	9.4%	5.3%	-4.5%
Commercial	37.5	0.8	2.1%	0.1%	-22.5%
OUD MAT	245.6	9.7	3.9%	-28.8%	20.6%
OUD Other Tx	381.5	--*	--*	0.7%	--*
Women 15-44	91.7	1.5	1.6%	-11.0%	-35.1%

IP = Inpatient; ACSC = Ambulatory Care Sensitive Conditions;
*Numbers too small to report

Table 15: Rate of All-Cause Hospital Readmissions within 30 Days

	2013	***2018***	***% Change***
VHCURES Pop.	11.0%	11.8%	6.9%
Blueprint PCMH	11.0%	11.8%	7.4%
Other Primary Care	11.5%	12.1%	5.3%
No Primary Care	6.6%	6.5%	-1.2%
Medicaid	10.7%	15.3%	42.4%
Medicare	12.2%	11.7%	-3.5%
Commercial	5.2%	7.3%	41.2%
OUD MAT	11.1%	17.5%	56.8%
OUD Other Tx	14.5%	23.6%	62.6%
Women 15-44	7.0%	12.9%	84.3%

Note: same results for the VHCURES Population and the Blueprint PCMH are due to rounding errors.

Total Resource Use and Trends

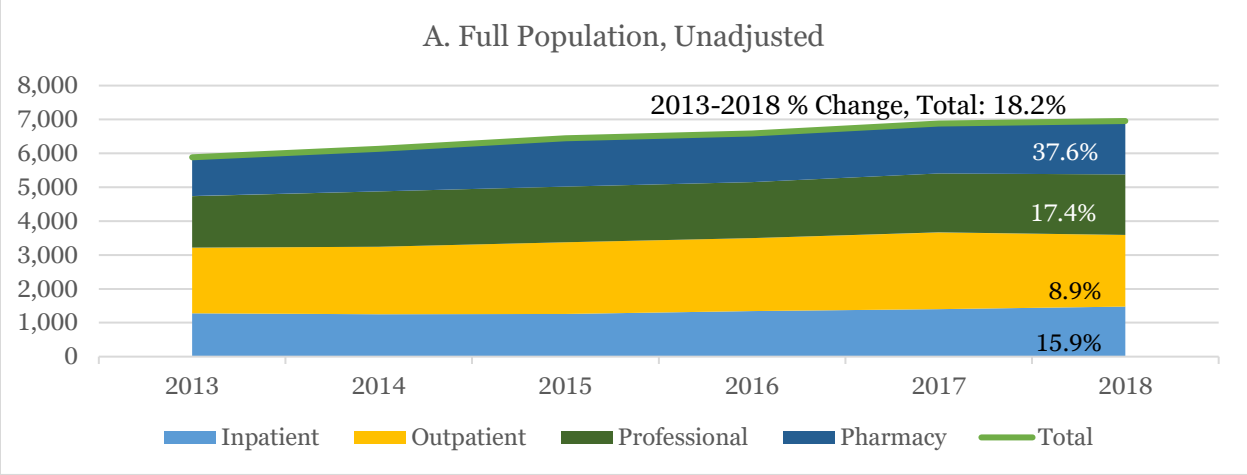
Another approach to evaluate utilization, is the Total Care Relative Resource Value™ (TCRRV) or Total Resource Use, developed by HealthPartners. This method assesses health care utilization across four categories[12] of services based on a standardized measure of relative economic resources consumed, rather than by counting the number or rate of individual procedures or services. For example, a surgery uses more resources than a primary care visit; therefore, an individual with one surgical procedure and one primary care visit will have a higher resource score than someone with three primary care visits. The methodology also assigns a standardized relative cost to various procedures or services to eliminate the distortion caused by variation in pricing across providers, regions and payers. The below analysis reviews the Total Resource Use over time, stratified by its four categories to assess trends in utilization.

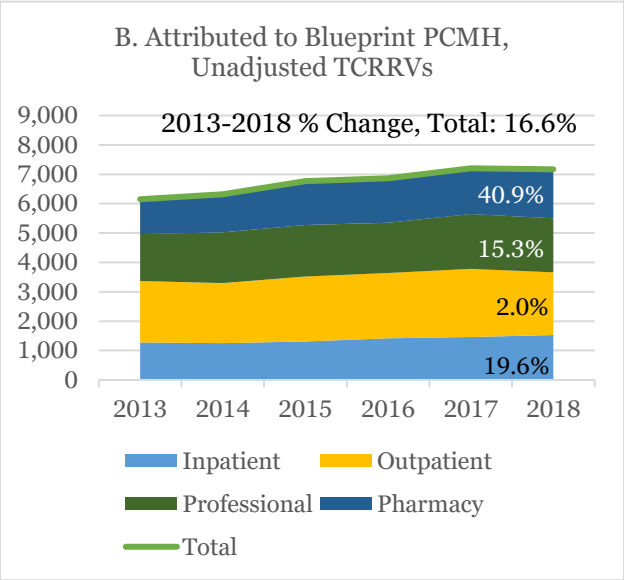
- Overall Total Resource Use grew by 18.2% between 2013 and 2018.
- Increases in use of professional services, inpatient, and pharmacy drove the increases in Total Resource Use.
- The Blueprint PCMH group had lower Total Resource Use in 2018 and lower growth overtime than the Other Primary Care group (16.6% growth versus 21.6% growth), despite the Blueprint PCMH group having higher disease burden (see health status and chronic condition prevalence) and inpatient discharge rates. This finding could indicate care from community health teams and PCMHs have successfully limited intensive resource utilization; however additional analysis on diagnoses and service utilization patterns are needed to assess this hypothesis.
- When adjusted for age, sex, payer, and health status, we see the trend hold, indicating that the lower resource use by the Blueprint PCMH group is not simply due to demographics.

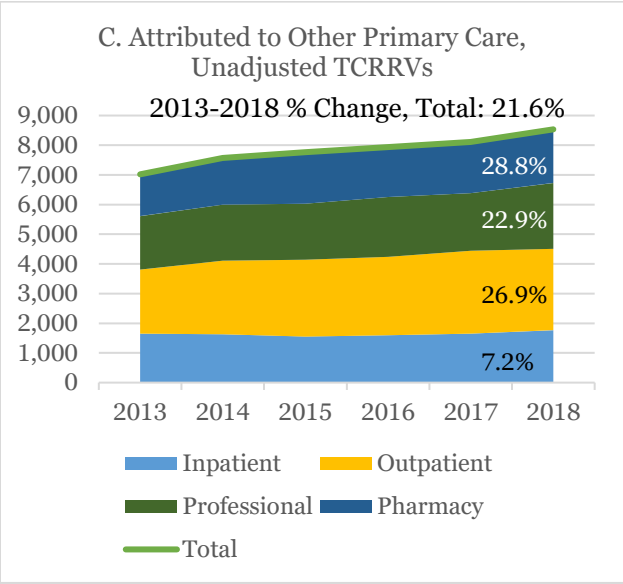
[12] TCRRV categories:

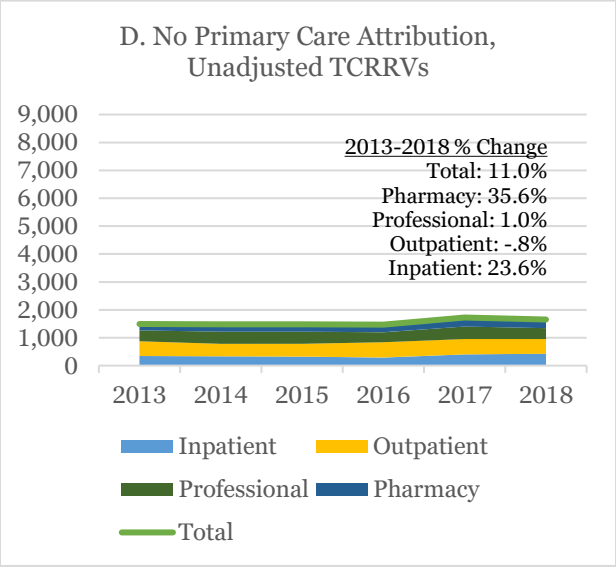
- Inpatient: facility claims for inpatient stays e.g. for knee replacement surgery, vaginal delivery, pneumonia, skilling nursing facility
- Outpatient: facility claims outpatient procedures e.g., knee arthroscopy, colonoscopy, MRI, mammogram, emergency department visit
- Professional: professional provider claims for procedures or services, e.g., knee arthroscopy, colonoscopy, MRI, mammogram, office visits, behavioral health therapy
- Pharmacy: medications to treat diabetes, asthma, depression, high blood pressure, high cholesterol, pain, cancer, infections, gastrointestinal conditions. Does not include medications dispensed in a medical setting.

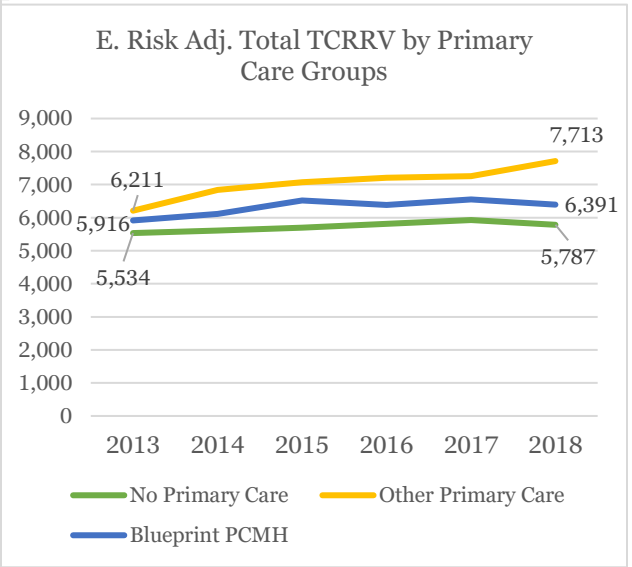
Figure 11: Trends in Total Resource Use by Categories, VHCURES and Primary Care Populations







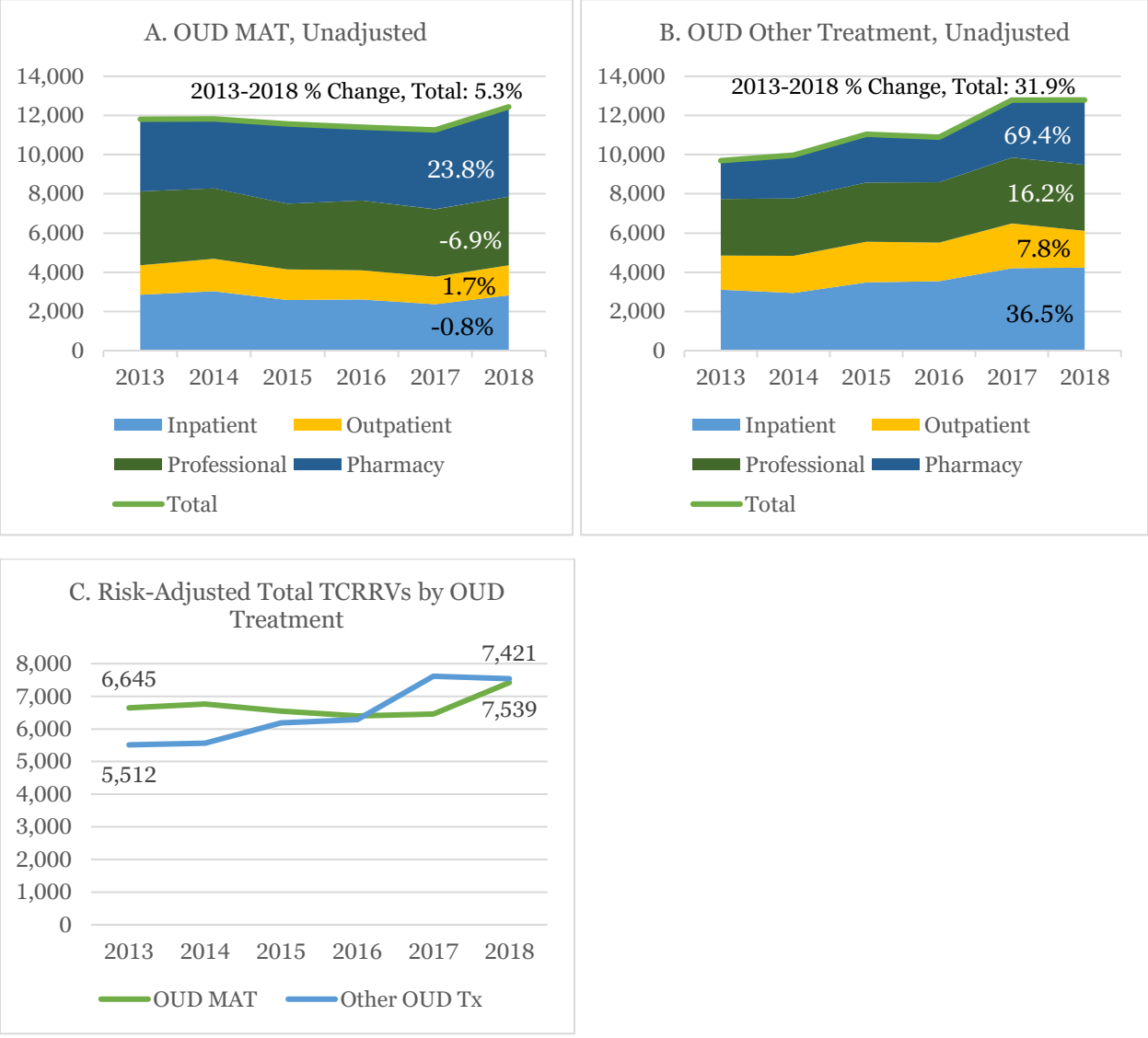




Total Resource Use for Opioid Use Disorder Sub-Populations

- The OUD MAT group has high pharmacy use, which includes the use of MAT such as buprenorphine. However, the percent change over time showed a declining trend, whereas the OUD Other Treatment group had increases in pharmacy use of non-MAT medications.
- The OUD MAT group also has lower and declining inpatient care while the OUD Other Treatment group's inpatient use increased by 36.5%. Given the demographic similarities of these groups, this trend may be is associated with better treatment and care management.
- When looking at the adjusted Total Resource Use, both groups overall have similar resource use with variation between years.

Figure 12: Trends in Total Resource Use by Categories, Opioid Use Disorder Populations



QUALITY MEASURES – ALCOHOL, DRUG DEPENDENCE AND MENTAL HEALTH

Reducing the number of deaths due to suicide and overdose are key population health goals for Vermont. Assuming that timely and appropriate interaction with the health, mental health, and alcohol and substance use treatment systems can help reduce deaths from suicide and overdose, the below analysis reports on the rates of treatment engagement for people diagnosed with mental health and alcohol and substance use conditions. Due to 2015 changes in how the below measures were calculated, we report only years 2016 through 2018.

Alcohol and Substance Use Initiation and Engagement in Treatment

The "Initiation and Engagement for Alcohol and Other Drug Dependence Treatment" measure addresses how people with an alcohol or drug dependence begin to interact with treatment services. Initiation measures the percent of people with an index event of alcohol or drug dependence diagnosis who begin treatment within 14 days. Engagement refers to the percentage of those with an index event who are still in treatment at 30 days. For the alcohol or other drug dependence measure, those with a history of OUD diagnosis and MAT are reported separately. The Agreement sets the target for Initiation at the 50th percentile compared to national health plans by the end of 2022, and for engagement, at the 75th percentile for patients with alcohol or other drug dependence attributed to the ACO meeting engagement criteria (also by the end of 2022). Of note, this measure captures initiation recorded in claims and omits initiation in settings or by providers that do not generate a related claim.

- Measures of initiation in treatment after a new diagnosis of alcohol or substance use disorder are 38% indicating opportunity for future improvement.
- Rates of initiation for both primary care groups declined between 2016 and 2018. The rates of engagement for the Blueprint PCMH group also decreased. In both initiation and engagement, the Blueprint PCMH group's rates were significantly lower than the Other Primary Care group.
- The OUD MAT group stands out as having a high rate of both initiation and engagement. Two factors could contribute to this finding. First, the higher rate could reflect a positive impact from Vermont's investment in the Hub and Spoke system of care. Second, it also likely reflects the willingness of people with an OUD to seek treatment.

Table 16: Initiation and Engagement for Alcohol and Other Drug Dependence Treatment

	Index Diagnosis	***Initiation***		***Engagement***	
	2018 N	**2018%**	**% Change from 2016**	**2018%**	**% Change from 2016**
VHCURES Pop.	8,302	38%	-11.6%	16%	-4.9%
Blueprint PCMH	6,108	37%	-14.0%	15%	-6.6%
Other Primary Care	1,827	40%	-7.0%	18%	0.5%
No Primary Care	367	44%	7.3%	22%	-4.4%
Medicaid	4,083	40%	-11.1%	20%	-4.5%
Medicare	2,226	40%	-4.8%	9%	-11.8%
Commercial	1,994	33%	-5.7%	17%	-0.1%
OUD MAT	691	61%	5.2%	45%	13.0%
OUD Other Tx	278	43%	-12.2%	24%	-5.8%
Women 15-44	1,738	37%	-17.8%	20%	-8.4%

Follow-up after ED Visit for Alcohol, Other Drug Dependence, or Mental Health Reasons

Another measure of how Vermont's system of care serves those with an alcohol or other drug dependence and mental health diagnoses is whether individuals receive follow-up services after an ED visit for these conditions. These ED follow-up measures address the degree to which communication and care coordination successfully aid individuals in accessing appropriate treatment after an index event of ED use. The Agreement goals are to achieve follow-up care within 30 days for 60% of ED discharges due mental health and follow-up care for 40% of ED discharges due to alcohol or other drug dependence.

- Follow-up treatment for mental health conditions within 30 days appears to be above the Agreement target for most populations, while the follow-up for alcohol and other drug dependence is well below the Agreement target.
- The differences between Blueprint PCMH and Other Primary Care group for follow-up with seven days and 30 days for both alcohol or other drug dependence or mental health were not statistically significant. However, the Blueprint PCMH proportions with follow-up for alcohol and other drug dependence by 7- and 30-days increased between 2016 and 2018, whereas the Other Primary Care group's proportion decreased. For mental health, this pattern was the same at 7 days, but at 30 days, the Other Primary Care group showed a slight increase whereas the Blueprint PCMH group showed no change over time.
- The differences between the OUD MAT and OUD Other Treatment groups for the 7- and 30-day follow-up in both measures was not statistically significant, although rates for follow-up for SUD increased, while the follow-up rates for mental health declined.
- Of note, one drawback to these claims-based measures is they do not reflect the care rendered by Spoke staff or Community Health Teams, or fully capture those services that are billed monthly, such as at Hubs or CRT case rates.

Table 17: Percent of ED Visits for Alcohol or Other Drug Dependence with Follow-Up After Discharge

		7-Day		*30-Day*	
	2018 ED Visits for SUD	**2018 % w/ follow-up**	**% Change from 2016**	**2018 % w/ follow-up**	**% Change from 2016**
VHCURES Pop.	2,424	25%	4.2%	25%	4.2%
Blueprint PCMH	1,724	25%	8.7%	26%	8.3%
Other Primary Care	561	27%	-3.6%	27%	-3.6%
No Primary Care	139	14%	-6.7%	15%	-6.3%
Medicaid	1,629	28%	3.7%	28%	0.0%
Medicare	534	20%	0.0%	21%	5.0%
Commercial	261	15%	12.3%	15%	14.9%
OUD MAT	780	33%	6.5%	34%	6.3%
OUD Other Tx	100	35%	9.4%	35%	2.9%
Women 15-44	701	27%	-3.6%	28%	-3.4%

Table 18: Percent of ED Visits for Mental Health with Follow-Up After Discharge

		7-Day		*30-Day*	
	2018 ED Visits for Mental Health	**2018 % w/ follow-up**	**% Change from 2016**	**2018 % w/ follow-up**	**% Change from 2016**
VHCURES Pop.	3,940	76%	1.3%	83%	0.0%
Blueprint PCMH	3,059	77%	1.3%	84%	0.0%
Other Primary Care	772	74%	-1.3%	82%	1.2%
No Primary Care	109	61%	10.9%	72%	18.0%
Medicaid	2,493	83%	3.7%	87%	1.2%
Medicare	980	61%	-6.2%	73%	-5.2%
Commercial	467	71%	-5.3%	82%	0.0%
OUD MAT	237	74%	-7.5%	80%	-10.1%
OUD Other Tx	58	81%	-3.6%	83%	-4.6%
Women 15-44	1,357	81%	1.3%	87%	0.0%

QUALITY MEASURES: ASTHMA

The last measure we report on is a quality measure assessing appropriate treatment for asthma among those 5 to 64 years of age. This measure has two components: 1) those who remain on appropriate medication for 50% of the treatment period; and 2) those who remain on the medication for 75% of the treatment period.

- The proportions of those who remain on their asthma medication treatment for more than 50% and 75% of the treatment time in the Blueprint PCMH and the Other Primary

Care groups are not significantly different over time, though the Blueprint PCMH group shows a decline over time at both targets.

Table 19: Medication Management for People with Asthma (MMA) – Percent Remaining on Medication

		On Medication for 50% of Treatment Time		***On Medication for 75% of Treatment Time***		
	2018 N with Asthma	2018%	% Change from 2016	2018%	% Change from 2016	Difference from 50% to 75%
VHCURES Pop.	4,966	63%	0.0%	44%	-2.2%	19%
Blueprint PCMH	3,896	63%	-1.6%	44%	-2.2%	19%
Other Primary Care	1,004	64%	3.2%	43%	-6.5%	21%
No Primary Care	66	59%	9.3%	44%	41.9%	15%
OUD MAT	169	36%	-12.2%	20%	-23.1%	16%
OUD Other Tx	*	n/a	n/a	n/a	n/a	n/a
Women 15-44	1,242	59%	-1.7%	38%	-11.6%	21%

* Numbers too small to report.

PATIENT EXPERIENCE

Each year, the Blueprint for Health invites primary care practices to participate in the Consumer Assessment of Healthcare Providers and Systems (CAHPS) PCMH survey. This survey evaluates patients' experiences in their primary care practices and with their primary care provider. The topics covered by the CAHPS survey include access to care, communication, coordination of care, information, self-management care, and specialists. The survey results reported here show statewide results. The timing between receiving these results and the due date for this report did not allow for hospital service area analysis. Practice-level results are shared directly with the practices and are used for quality improvement. The results below are from the survey fielded from September through November of 2018 and were reported in last year's Blueprint Annual Report. Results for the survey fielded from September through December 2019 will not be available until mid-February 2020.

Based on the below results, while providers receive high marks for how they communicate with their patients, areas for improvement include access to care, coordination of care, providing information about the practice or appointments, and self-management. This latter composite is of especial interest because it addresses a patient's engagement in his or her own health, which is a critical component of establishing healthy behaviors or monitoring or treating health conditions.

Table 20: 2018 Patient Experience Composite Outcome

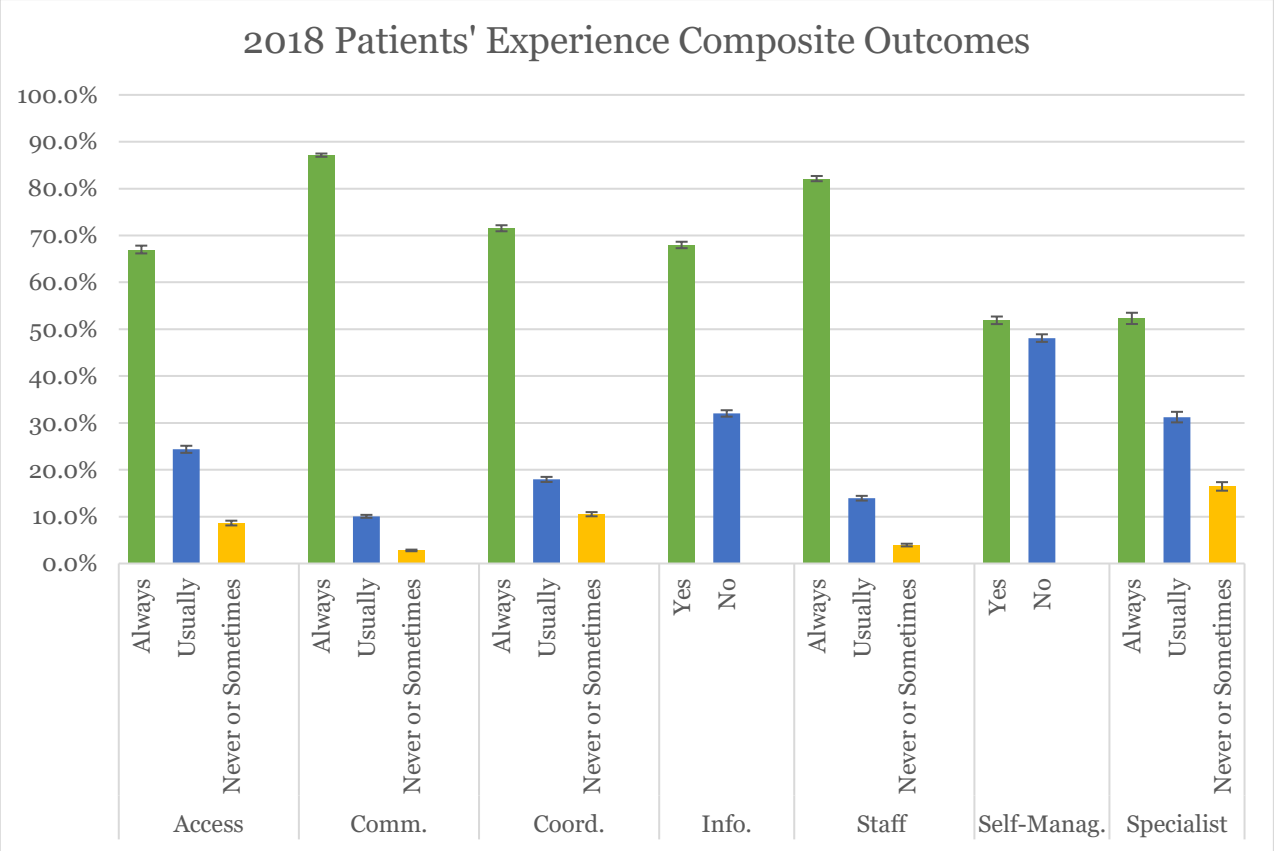


Table 21: Questions Associated with Each Patient Experience Composite

Access Composite	In the last 6 months, when you contacted this provider's office to get an appointment for care you needed right away, how often did you get an appointment as soon as you needed?
	In the last 6 months, when you made an appointment for a check-up or routine care with this provider, how often did you get an appointment as soon as you needed?
	In the last 6 months, when you contacted this provider's office during regular office hours, how often did you get an answer to your medical question that same day?
Communication Composite	In the last 6 months, how often did this provider listen carefully to you?
	In the last 6 months, how often did this provider show respect for what you had to say?
	In the last 6 months, how often did this provider explain things in a way that was easy to understand?
	In the last 6 months, how often did this provider spend enough time with you?
Coordinated Care Composite	In the last 6 months, when this provider ordered a blood test, x-ray, or other test for you, how often did someone from this provider's office follow up to give you those results?
	In the last 6 months, how often did you and someone from this provider's office talk at each visit about all the prescription medicines you were taking?
	In the last 6 months, how often did this provider seem to know the important information about your medical history?
Information Composite	Did this provider's office give you information about what to do if you needed care during evenings, weekends, or holidays?
	Some offices remind patients between visits about tests, treatment or appointments. In the last 6 months, did you get any reminders from this provider's office between visits?
Office Staff Composite	In the last 6 months, how often were clerks and receptionists at this provider's office as helpful as you thought they should be?
	In the last 6 months, how often did clerks and receptionists at this provider's office treat you with courtesy and respect?
Self-Management Composite	In the last 6 months, did someone from this provider's office ask you if there are things that make it hard for you to take care of your health?
	In the last 6 months, did someone from this provider's office talk with you about specific goals for your health?
Specialist Composite	In the last 6 months, how often was it easy to get appointments with specialists?
	In the last 6 months, how often did the specialist you saw most seem to know the important information about your medical history?

WOMEN'S HEALTH

Finally, while we have reported many of the health utilization, expenditures and outcomes for women age 15 to 44 throughout this report, we would also like to call special attention to this group as the constituency of the Blueprint's Women's Health Initiative. This program launched in 2017, so the data in this report covers the implementation and expansion of this program. The program has not been at scale long enough to measure any changes that might be attributed to the Initiative. Therefore, the results presented in this report serve as a baseline of women's health in the period leading up to and during the expansion of the Women's Health Initiative:

- Medicaid enrollment makes up a larger proportion of women 15 to 44 (43.3%) compared to the VHCURES population (30.4%). One reason for this difference could be the broader Medicaid eligibility for pregnant women.
- While there has been a slight shift from healthy to higher risk categories, this group remains relatively healthy with low prevalence of the three chronic conditions highlighted in this report. Of those with hypertension that could be linked to clinical data, women in this age group was similar to the VHCURES population for in hypertension control, but worse in diabetes.
- Women age 15 to 44 had lower total PMPY expenditures compared to the VHCURES population, and the group's annual growth in PMPY expenditures was 2.7%.
- Women in this group had similar primary care utilization as the VHCURES population. However, given many women rely on their obstetrician-gynecologist for their primary care needs additional analysis is needed to understand the full primary care utilization patterns of this group.
- Area for potential improvement include potentially avoidable emergency department visits and readmission within 30 days of an inpatient discharge. Both rates were higher for women age 15-44 than the VHCURES population.

As the Blueprint continues its evaluation of the Women's Health Initiative in 2019 and onward, we will continue to monitor changes in expenditures, settings in which care is received, and rates of potentially avoidable utilization as enhanced care coordination, family planning services, and screening services are implemented through the program.

CONCLUSION

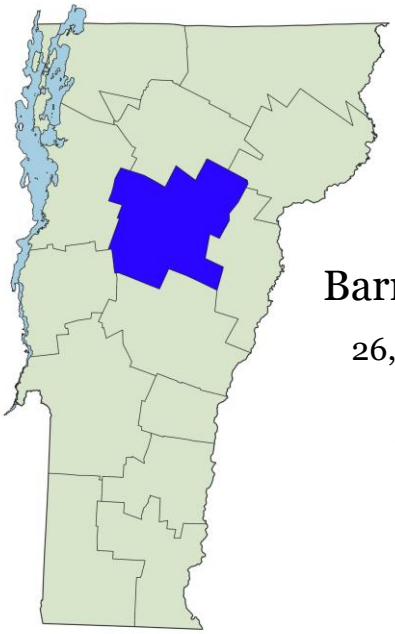
The data presented here reviews trends for the full Vermont population (as available in VHCURES) and select subpopulations. The findings indicate areas with positive outcomes over time as well as opportunities for improvement through collaborate across partners in Vermont's health system. For example, those attributed to a PCMH in Vermont, despite having higher disease burden, have lower costs and utilization. This pattern holds true regardless of whether the results are crude or adjusted for age, gender, payer, health status, etc. For the population with an OUD diagnosis, despite having similar demographics and health status, those receiving MAT through the Hub & Spoke program have lower medical utilization. However, the rates of potentially avoidable utilization and the low rates of follow-up and engagement in treatment for those with an SUD or mental health condition indicate more work needs to be done.

The shift in how the Blueprint evaluates the services supported through its programs within the context of the broader health system provides valuable findings, but also identifies areas for additional analysis. Future areas for analysis include connecting claims data to other data sets to understand how different services intersect and identify the total per capita costs across sectors. For example, using Vital Statistics to identify women and their newborns, not always an easy or clear task in claims could allow us to see the connections between risk factors, adverse birth outcomes (such as low birthrate), and costs over the first year or two of life. Another type of study could provide a deeper understanding of the dynamics or factors driving the expenditure, utilization, and outcome results seen in this report. For example, a more detailed look at the population with diabetes could reveal comorbidities contributing to cost, impact of treatment adherence on control of diabetes and utilization of services, etc. Future evaluations of this type can inform program design within the Blueprint, such identifying priorities or strategies for

improving care management, or support decision-making or allocation of resources across the broader health and human services landscape.

7 HEALTH SERVICE AREA HIGHLIGHTS FOR 2019

The following section offers a by-the-numbers look at Blueprint activities in each health service area, health care expenditures for the nearest hospital service area in 2018, and highlights of the year in the words of each Blueprint Program Manager.



Barre Health Service Area

Program Manager: Mark Young

Barre By The Numbers

26,844	Primary care patients served at Blueprint practices in the past 2 years (based on insurance claims)
13.4	Community Health Team staff full time equivalents (FTEs)
4.8	Spoke staff FTEs
1	Women's Health Initiative staff FTEs
9	Self-management workshops held
38	Self-management workshop graduates
11,410	Community Health Team encounters
243	Patients served in area Spokes (Medicaid only)

Barre Community Health Team

Barre Hospital Service Area Health Care Expenditures

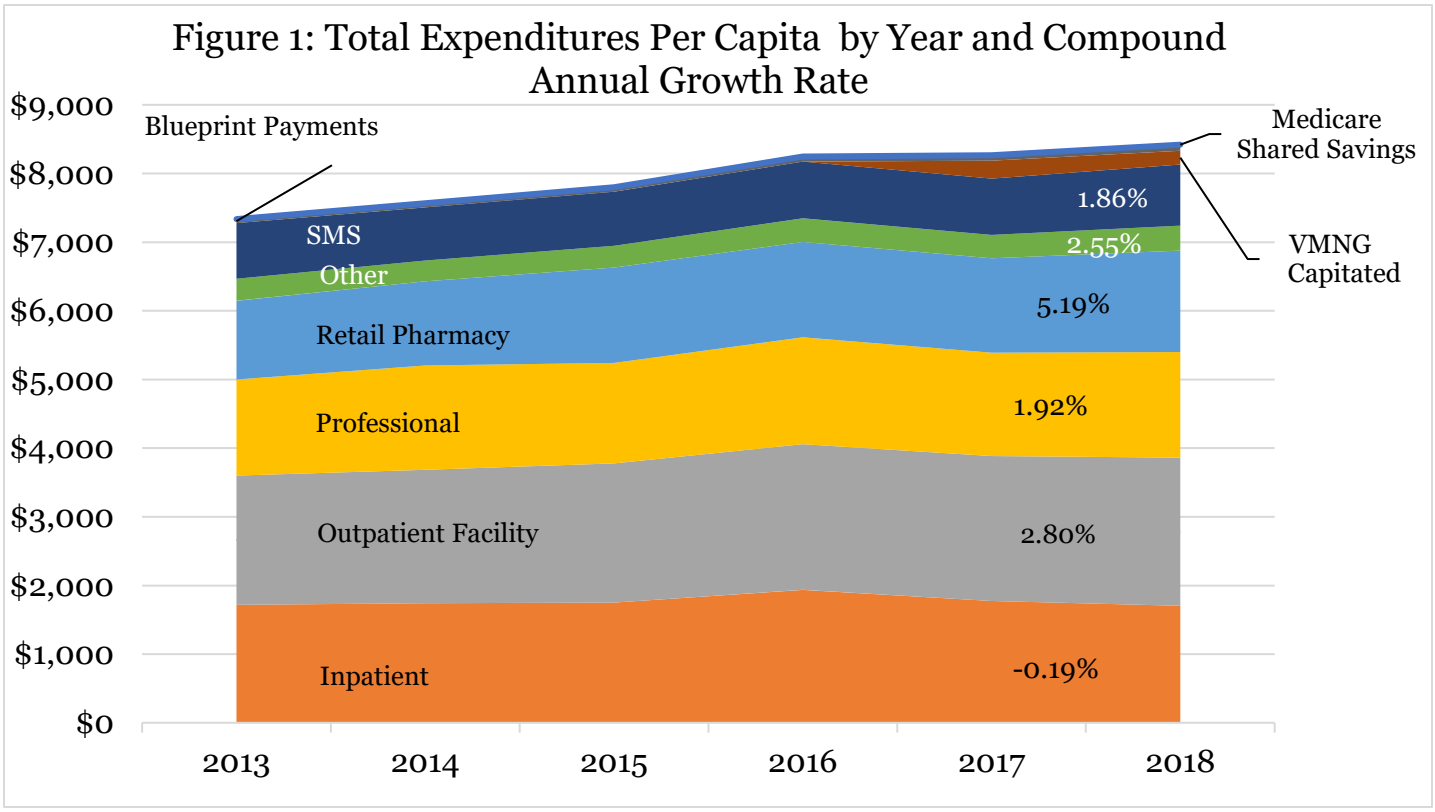


Figure 1: Presents unadjusted expenditures per capita by major category 2013-2018. The percentages on the right are the compounded annual growth across the time period. Every category showed increases except inpatient expenditures, which declined slightly.

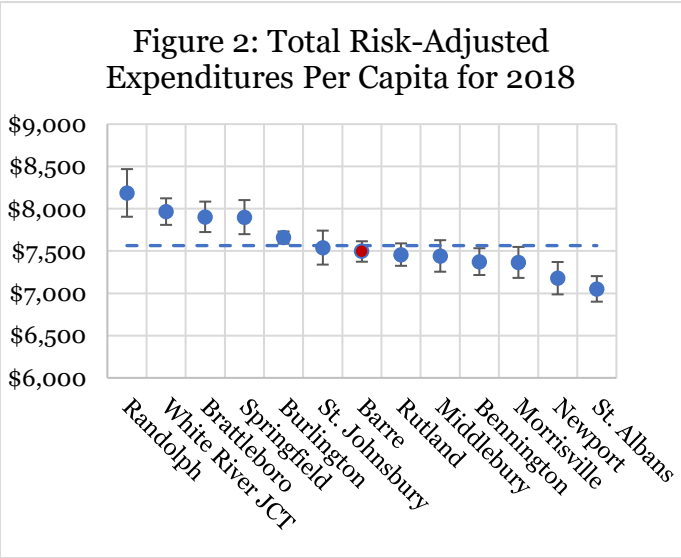


Figure 2: Presents annual risk-adjusted rates, including 95% confidence intervals. The blue dashed line indicates the statewide average. Barre is at the statewide average.

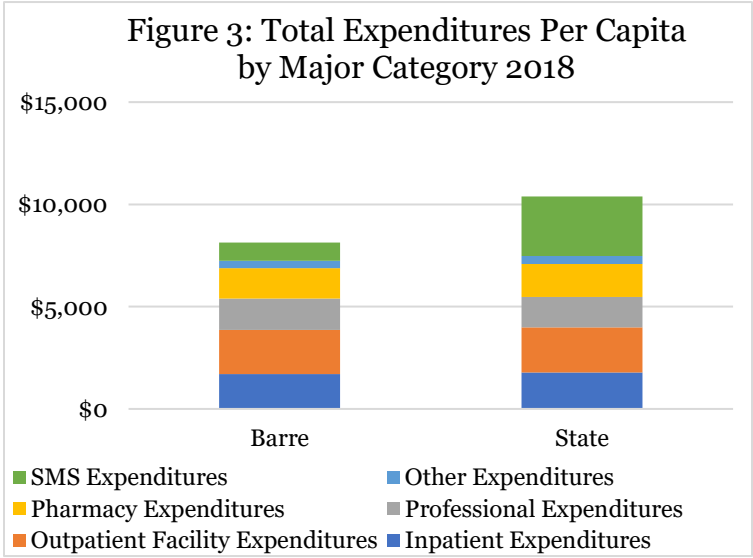


Figure 3: Presents 2018 non-adjusted rates, for the major categories of cost (as shown in Figure 1). Some services uniquely provided by Medicaid (e.g., case management, transportation) are reported separately as Special Medicaid Services (SMS). SMS expenditures in Barre are lower per capita than statewide.

BARRE HEALTH SERVICE AREA

Name of area Accountable Community for Health or Community Collaborative Group:
THE REGIONAL INVESTMENT IN EUDAIMONIA (HUMAN FLOURISHING)

The mission of THRIVE is "To optimize the health and wellbeing of our community through informed, collaborative, and innovative solutions". To fulfill this mission THRIVE brings together a broad range of community members, leaders, and health care and human service providers to design and implement joint solutions around specific issues related to prioritized population wellness indicators. Recent actions include the formation of two solution-focused Collaborative Action Networks to address transportation and homelessness service gaps.

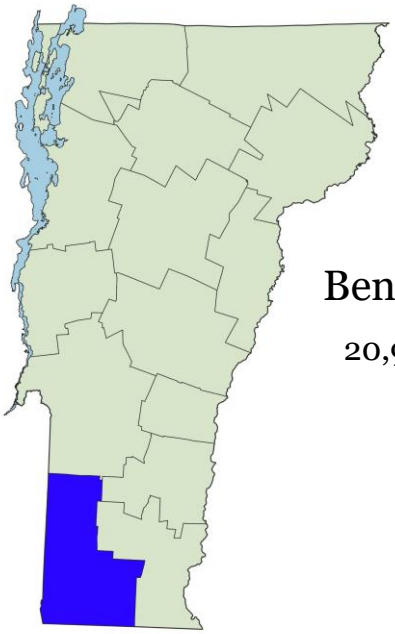
2019 ACHIEVEMENTS

Initiation and enhancement of self-management/Community Health Team (CHT) representation at community events/health fairs across Central Vermont. Events were planned sharing wellness materials, biometric health screenings, and seasonal recipes/nutritional analysis for a self-propelled smoothie blender bike. Feedback from community sparked additions to community promotion including an educational Plinko board/tissues/stress balls and thera-bands. A total of 11 successful events were held including Montpelier Alive, Revitalize Waterbury Art Festival, Barre Heritage Festival, and National Walk at Lunch Day as examples.

The creation of a new CHT webpage for Central Vermont was needed for community support and feasibility to access services. The complex build of the website was fully integrated to include language that accurately describes CHT services including Medication Assisted Treatment (MAT) and health and panel coordination. The CHT disciplines are linked to respective clinics with the nature of the CHT work outlined, contact information, and linkages to self-management programs/updated resource center.
https://www.cvmc.org/our-services/community-health-team

ADDITIONAL FEATURED PROJECTS

Central Vermont Medical Center in collaboration with the Washington County Substance Abuse Regional Partnership was the recipient of a Health Resources and Services Administration (HRSA) Rural Communities Opioid Response Program (RCORP) one-year planning grant. The grant allowed us to conduct needs assessments from which we determined priority areas of focus. As a result, we are developing plans to improve workforce, service delivery, and sustainability to address the opioid crisis in our community. The planning grant has allowed us to drill down into the data and host discussions across the wide spectrum of stakeholders impacted by the opioid crisis. These discussions have provided insights into our community's perception of the crisis and revealed needs of which we were previously unaware. Revelations from the community include the need for increased community awareness and outreach, the need to embrace the use of technologies to advance care (telemedicine and treatment support apps), and the need to improve access to care for those struggling with addiction. Through this work, we hope to leverage the resources and funding received from HRSA to further secure a three-year implementation grant starting in 2020.



Bennington Health Service Area

Program Manager: Kristi Cross

Bennington By The Numbers

20,928	Primary care patients served at Blueprint practices in the past 2 years (based on insurance claims)
9.1	Community Health Team staff full time equivalents (FTEs)
4.7	Spoke staff FTEs
0.5	Women's Health Initiative staff FTEs
7	Self-management workshops held
18	Self-management workshop graduates
13,640	Community Health Team encounters
368	Patients served in area Spokes (Medicaid only)

Bennington Community Health Team

Bennington Hospital Service Area Health Care Expenditures

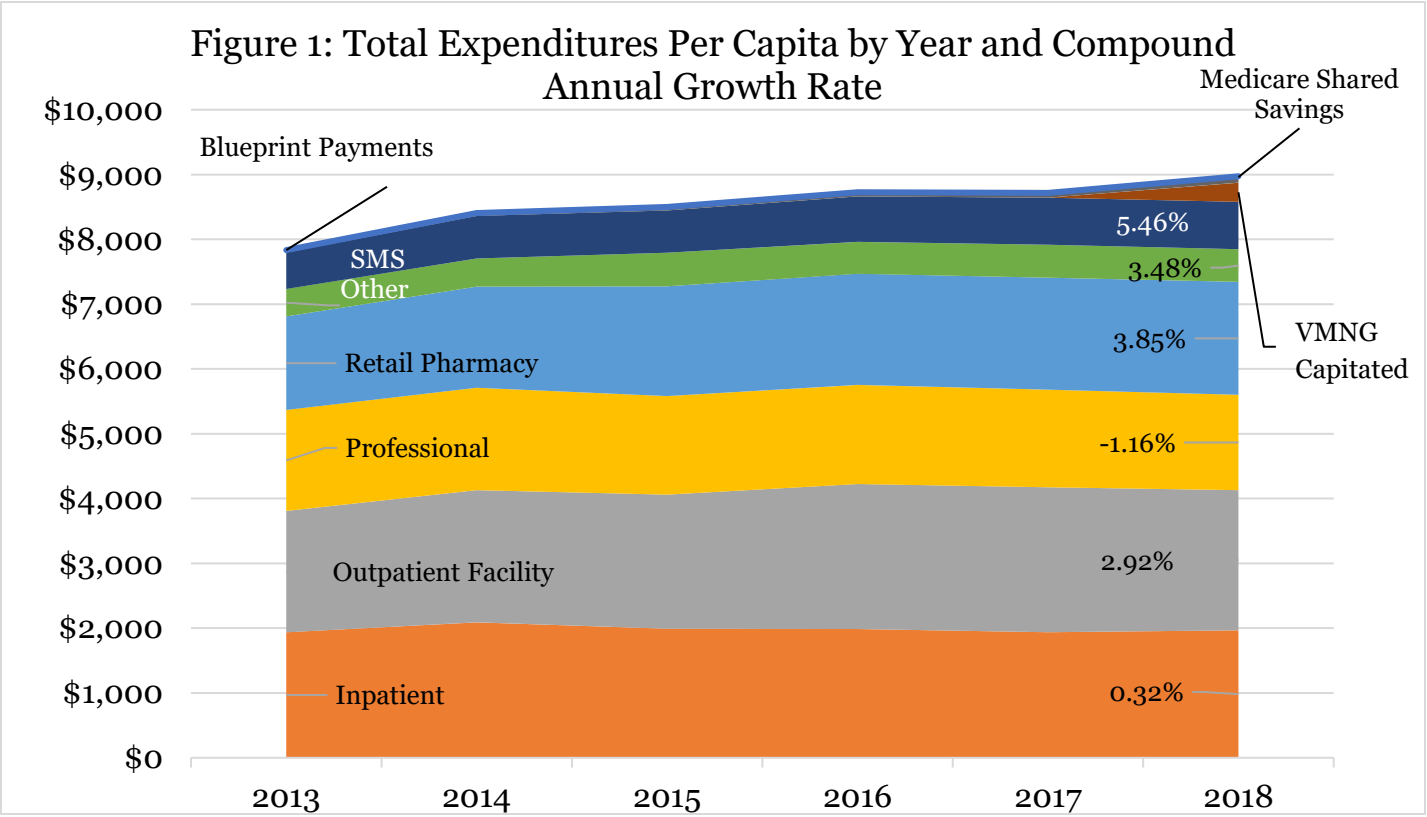


Figure 1: Presents unadjusted expenditures per capita by major category 2013-2018. The percentages on the right are the compounded annual growth across the time period. Every category showed increases except professional expenditures, which declined slightly.

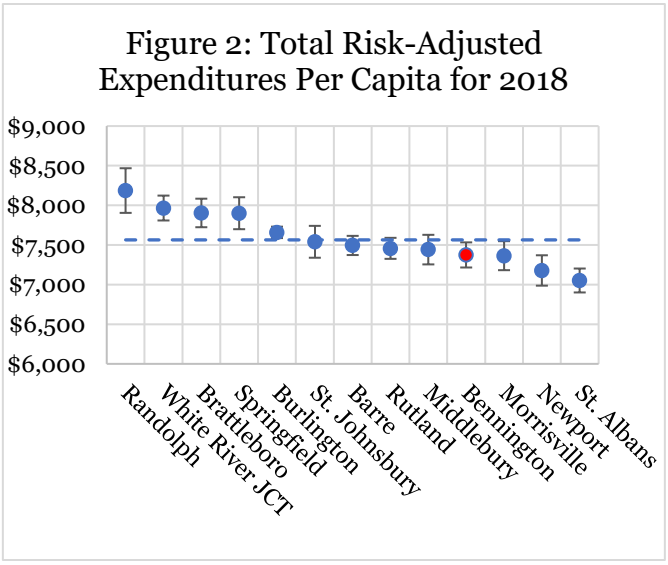


Figure 2: Presents annual risk-adjusted rates, including 95% confidence intervals. The blue dashed line indicates the statewide average. Bennington was slightly below the state average.

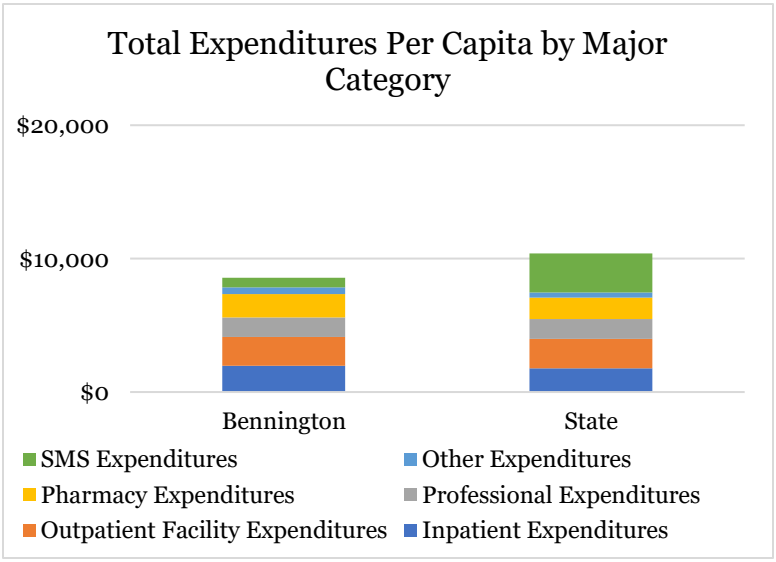


Figure 3: Presents 2018 non-adjusted rates, for the major categories of cost (as shown in Figure 1). Some services uniquely provided by Medicaid (e.g., case management, transportation) are reported separately as Special Medicaid Services (SMS). SMS expenditures in Bennington are lower per capita than statewide.

BENNINGTON HEALTH SERVICE AREA

Name of area Accountable Community for Health or Community Collaborative Group:

BENNINGTON COMMUNITY COLLABORATIVE

Goal: Build a high-performing system that supports measurable improvement in the health of the community

Purpose: The Bennington Health Service Area (HSA) Community Collaborative (CC) will identify and develop systems to support population health management in the Bennington Health Service Area to improve community health, support appropriate use of resources, and improve personal experience.

Definition of Health: (includes individual and community health) Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.

Scope: The scope of the Bennington Community Collaborative is to address population health in the Bennington HSA. The focus will be on quality outcomes, cost and value. The approach will be system-based change utilizing the structures of the Vermont Blueprint for Health, Vermont All Payer Model and the Bennington Accountable Community for Health.

2019 ACHIEVEMENTS

All Blueprint practices received NCQA Recognition.

The Bennington HSA spent considerable time and effort in meeting the goals of complex care coordination through OneCare VT. The process involved community partnership and collaboration, which strengthened the community and gave rise to a sense of purpose and process to achieve population health goals. This achievement had timely alignment with the success of RiseVT; the implementation of the $1 Million Mellon Grant to Bennington College for food insecurity; the inaugural Family Fitness Fest through the Supervisory Union; and other various community events that involved multiple community partners.

The Bennington Opioid Response Team had several achievements in 2019. It established a Project Coordinator; implemented Rapid Access to Medication Assistive Treatment (RAM) in the SVMC ED; opened a Syringe Services Program; Finalized an Opioid Response Strategic Plan complete with subcommittees on Youth Focused Initiatives, Behavioral Health and Hub/Spoke, Law Enforcement, and Recovery Housing. The team were awarded funding from the Vermont Community Foundation and a Community Action Grant through the Overdose Data to Action Grant. Key community partners were pulled in, which included transportation services, a local shelter, and the supervisory union. Bennington is also actively exploring the possibility of a Hub and has gained support from local and state legislation for many of the initiatives.

ADDITIONAL FEATURED PROJECTS

The first official subcommittees from the Bennington Community Collaborative were established this year- the Transportation subcommittee and an Oral Health subcommittee. The Transportation subcommittee was established in response to a collective awareness by many community partners that the foundational transportation resources in Bennington were largely unknown. The subcommittee came together to determine the population focus and next steps. To date, the subcommittee is comprised of twelve organizations and focused on same day access for non-emergent medical transportation and emergency department evening and night

discharge transports. The plan includes a focus on assessment, education, volunteerism, and funding. The Oral Health subcommittee is rooted in a funding opportunity to expand dental services to vulnerable youth populations.

Upcoming subcommittees for the Bennington Community Collaborative include work towards Suicide Prevention; Chronic Pain using mind, body, and medicine approaches; and Behavioral Health. All of these potential focused areas cross over into the work we are doing in the Opioid Response Plan and the other subcommittees to ensure appropriate overlap and avoid duplication.

Brattleboro Health Service Area

Program Manager: Rebecca Burns

Brattleboro By The Numbers

26,844	Primary care patients served at Blueprint practices in the past 2 years (based on insurance claims)
9.4	Community Health Team staff full time equivalents (FTEs)
3.2	Spoke staff FTEs
1	Women's Health Initiative staff FTEs
18	Self-management workshops held
44	Self-management workshop graduates
20,000+	Community Health Team encounters
129	Patients served in area Spokes (Medicaid only)

Brattleboro Community Health Team

Brattleboro Hospital Service Area Health Care Expenditures

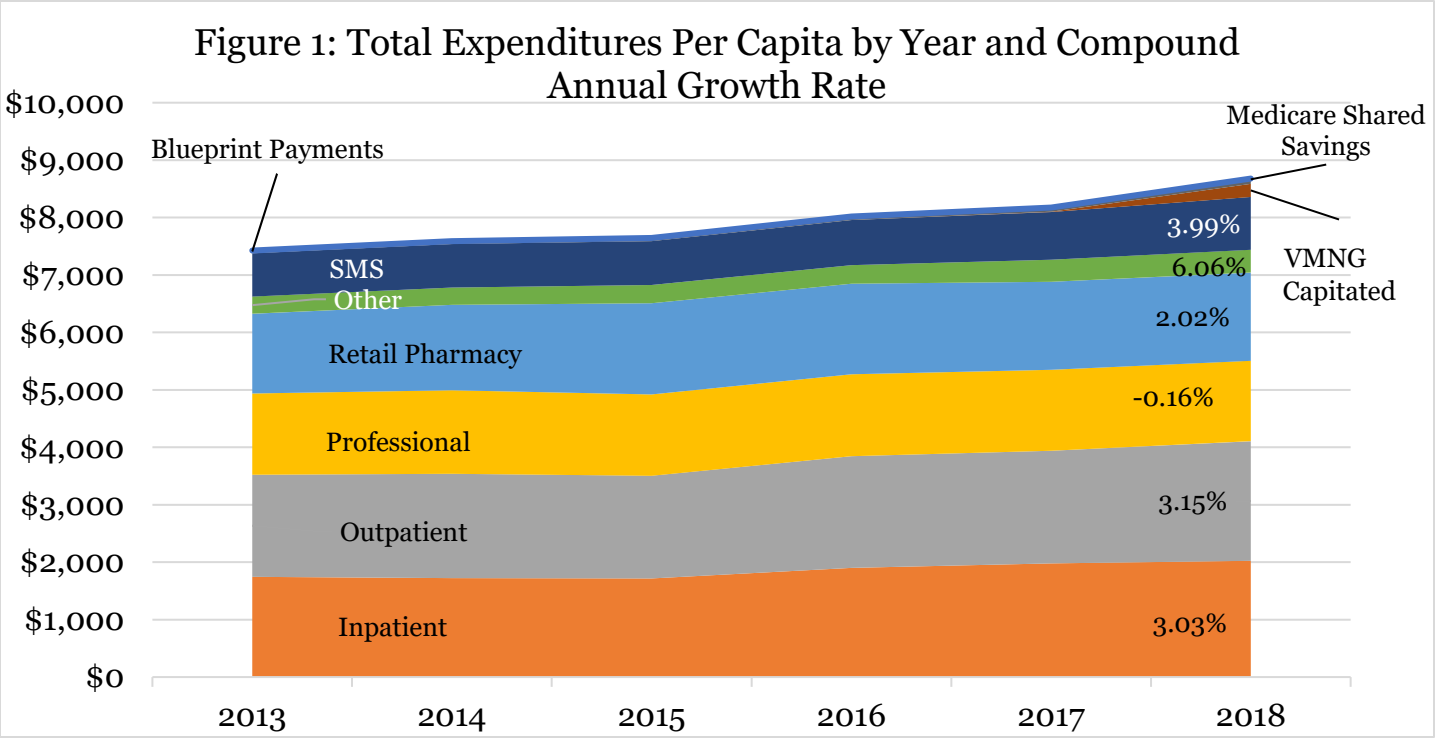


Figure 1: Presents unadjusted expenditures per capita by major category 2013-2018. The percentages on the right are the compounded annual growth across the time period. Every category showed increases except professional expenditures, which declined slightly.

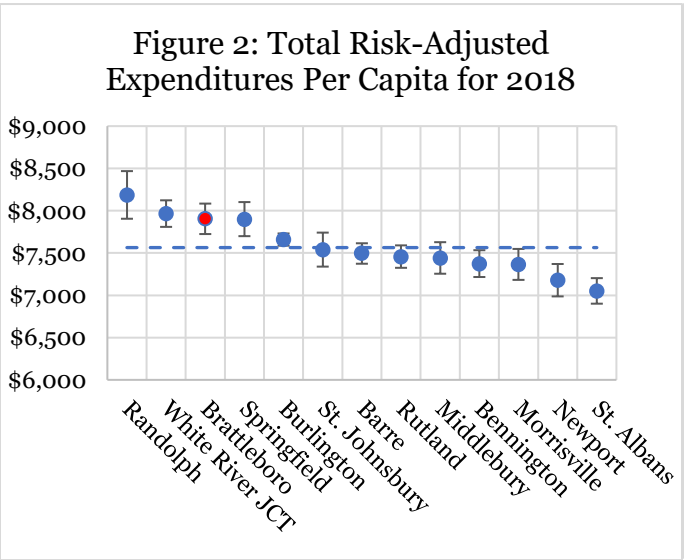


Figure 2: Presents annual risk-adjusted rates, including 95% confidence intervals. The blue dashed line indicates the statewide average. Brattleboro is above the state average.

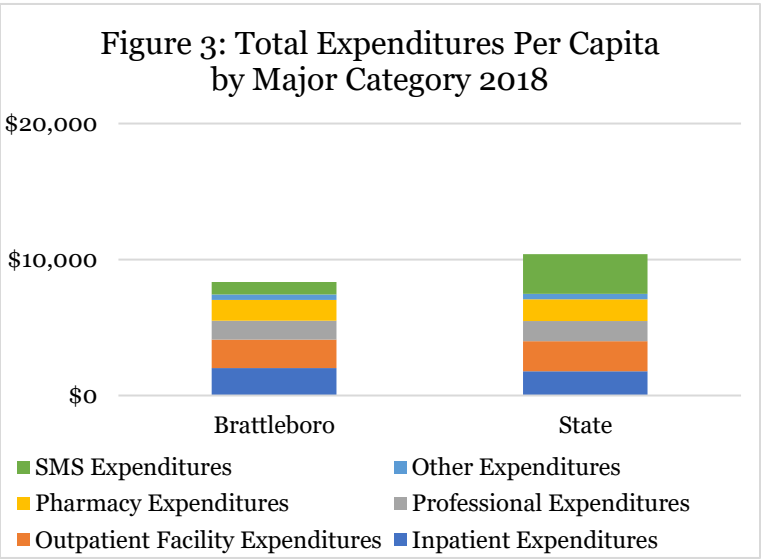


Figure 3: Presents 2018 non-adjusted rates, for the major categories of cost (as shown in Figure 1). Some services uniquely provided by Medicaid (e.g., case management, transportation) are reported separately as Special Medicaid Services (SMS). SMS expenditures in Brattleboro are lower per capita than statewide.

BRATTLEBORO HEALTH SERVICE AREA

Name of area Accountable Community for Health or Community Collaborative Group:

THE SOUTHEASTERN VERMONT ACH

The Southeastern VT ACH's goal is to build an integrated, high-performing network of partners that supports measurable improvement in meeting the needs of families and individuals in the community. The Southeastern VT ACH will develop systems to improve community health and well-being, support appropriate use of resources, and improve access and individual experience of community services. The Southeastern VT ACH consists of an Organizing Committee and a Full Committee. The Organizing Committee meets monthly and the Full Committee meets quarterly.

The work of the Southeastern VT ACH encompasses the population in the Brattleboro Health Service Area. The focus will be on quality outcomes, cost and value. The approach will be systems-based change utilizing the structures and resources of the VT Blueprint for Health, OneCare Vermont, the Agency of Human Services, and other guiding organizations. After reviewing the data from area hospitals' Community Health Needs Assessments and Agency of Humans Services Community Profiles, the group determined our overarching focus area over the next three years will be mental health. This was the overarching theme in the data. Our work is broken into four focus areas: clinical/medical projects, supports across the lifespan, social determinants of health and substance use disorder. We review the work being done in our community in these areas through a mental health lens.

2019 ACHIEVEMENTS

We would also like to highlight the care coordination that has happened, and continues to happen, in our HSA. We have provided various levels of care coordination with our patients, specifically around decreasing HgA1C's and assisting with housing, food insecurity, substance use disorder and mental health. We are continuing to expand how we provide diabetes care, education and outreach to our community through care coordination and clinical expertise with our CHT Registered Dieticians, Health Coach, Regional Coordinator and RN Care Coordinator. This also involves the primary care practices' staff and providers.

We have had six primary care practices achieve PCMH sustainability recognition, one practice who has just submitted and two practices that will be submitting this year. This was and continues to be a huge collaboration with the CHT, Primary Care Practices and the QI Facilitator. Systems were/are being developed and will continue to evolve to continue doing this important work of quality improvement for to best meet patient's needs.

ADDITIONAL FEATURED PROJECTS

The CHT Pool Program continues at the local Comfort Inn for another year with funding assistance from Senior Solutions, our local Area Agency on Aging. Patients are referred to the Community Health Team by their Primary Care Providers, to enlist in the pool program. This program is free of charge to participants.

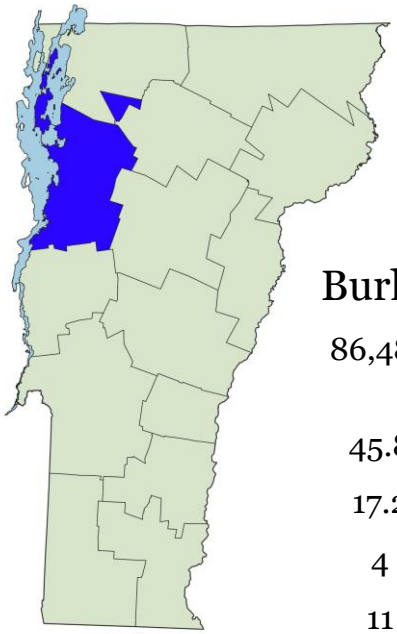
Prehab Program is new program started in 2019 by the Cardiac Rehab Department at BMH. This program is designed for high cardiac risk patients. The goal of the program is to keep

patients from having a cardiac event by intervening earlier with a 'cardiac rehab like program'. The class meets twice per week, two-hour sessions, for eight weeks. The focus of the class is on physical activity, nutrition education and medication education. This program was funded by a OneCare Vermont innovation grant. The CHT provides the nutrition education for the program along with being the referral source at this time.

A HRSA Implementation Grant was applied for by 15 community partners as a follow to the planning grant we received last year to assess substance use disorder in Windham County. Windham County Consortium on Substance Use (COSU) applied for an implementation grant and was awarded a one million dollar grant over three years to address substance use disorder in Windham County, which local Blueprint staff continue to be a part of.

Healthworks is a collaboration with Groundworks (our local shelter and drop-in center), the Brattleboro Retreat, HCRS and BMH Community Health Team. This collaboration embeds staff in the shelter and drop-in center to assist with meeting clients needs with the intention of assisting them integrate back into services, such as primary care. BMH embeds a registered nurse at Groundworks 24 hours per week to assist clients with obtaining a primary care provider, dentist and various other medical needs. The registered nurse works an employee of the community health team.

The Windham County Dental Center opened on May 21, 2019 with a focus to serve patients with Medicaid insurance. The center has seen over 500 patients for dental care, both restorative and preventative.



Burlington Health Service Area

Program Manager: Kerry Sullivan

Burlington By The Numbers

86,482	Primary care patients served at Blueprint practices in the past 2 years (based on insurance claims)
45.8	Community Health Team staff full time equivalents (FTEs)
17.2	Spoke staff FTEs
4	Women's Health Initiative staff FTEs
11	Self-management workshops held
80	Self-management workshop graduates
15,753	Community Health Team encounters (UVMMC only)
670	Patients served in area Spokes (Medicaid only)

Burlington Community Health Team

Burlington Hospital Service Area Health Care Expenditures

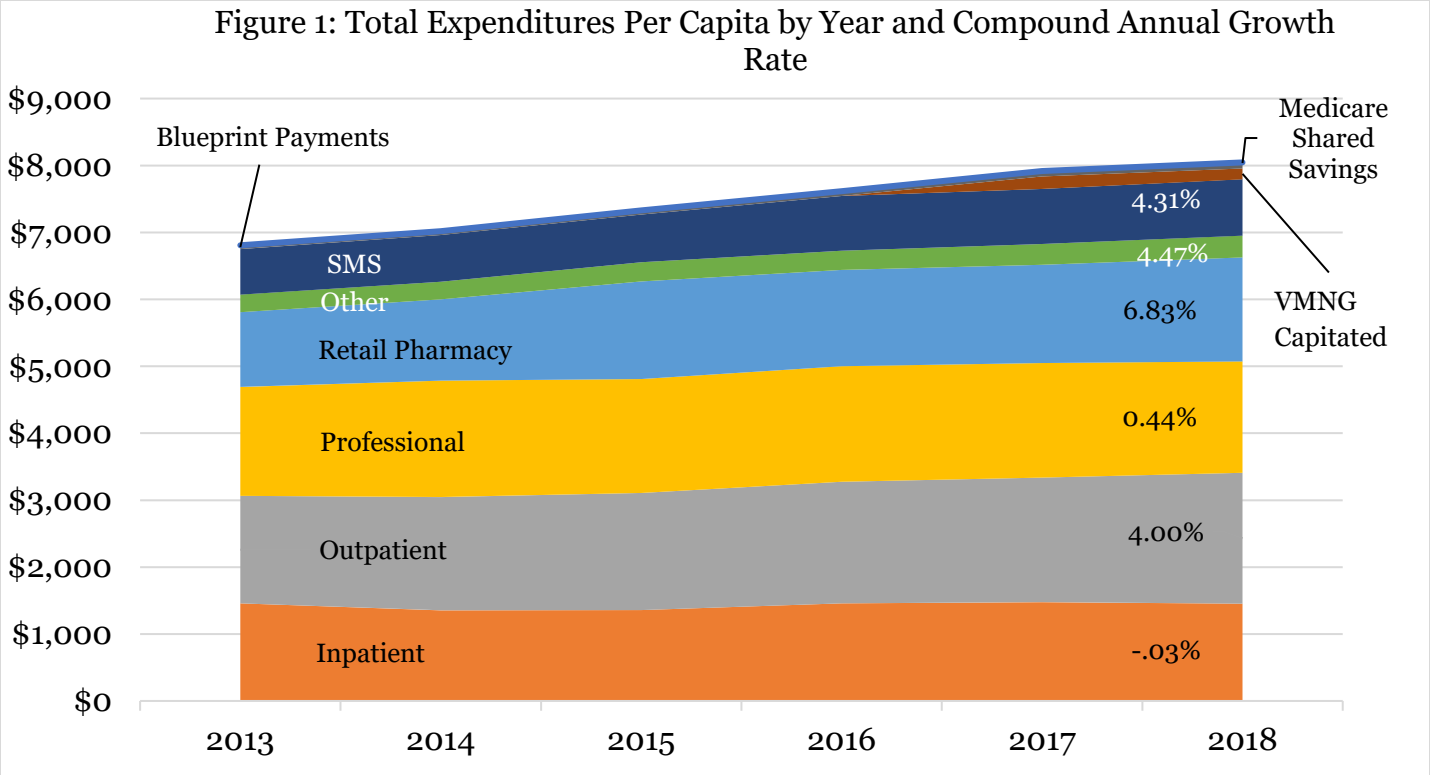


Figure 1: Presents unadjusted expenditures per capita by major category 2013-2018. The percentages on the right are the compounded annual growth across the time period. Every category showed increases except inpatient expenditures, which declined slightly.

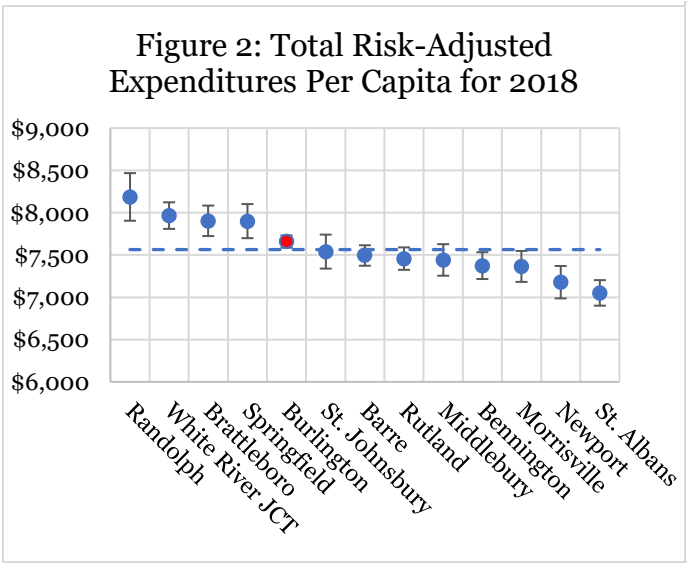


Figure 2: Presents annual risk-adjusted rates, including 95% confidence intervals. The blue dashed line indicates the statewide average. Burlington is slightly above the statewide average.

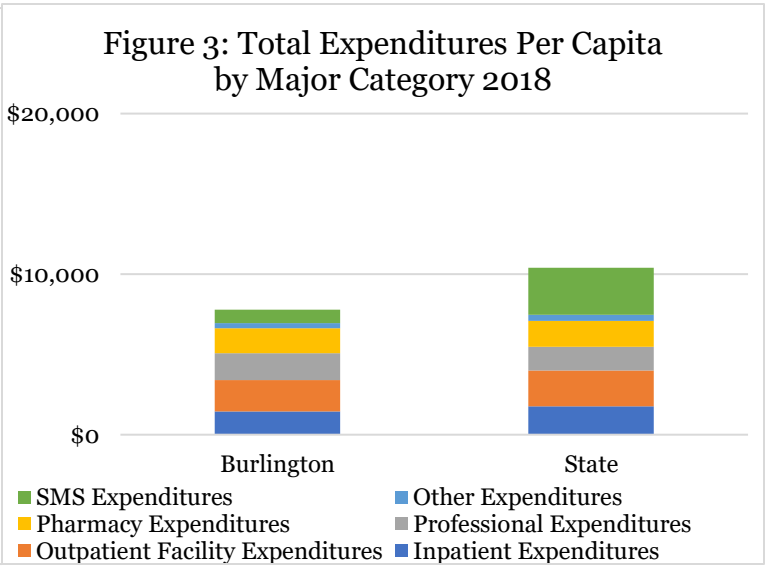


Figure 3: Presents 2018 non-adjusted rates, for the major categories of cost (as shown in Figure 1). Some services uniquely provided by Medicaid (e.g., case management, transportation) are reported separately as Special Medicaid Services (SMS). SMS expenditures in Burlington are lower per capita than statewide.

BURLINGTON HEALTH SERVICE AREA

Name of area Accountable Community for Health or Community Collaborative Group:

CHITTENDEN COUNTY ACCOUNTABLE COMMUNITY FOR HEALTH (CACH)

The vision of CACH is to ensure that Chittenden County is a healthy place to live, work, play, learn, and achieve spiritual and personal growth. In order to realize this vision, CACH operates according to its goal of achieving population health through collaboration as informed by and in alignment with the Community Health Needs Assessment (CHNA) and ECOS. Goals are achieved by effectively and strategically utilizing all three teams within CACH (Core Team, Action Team, and Consulted/Informed Team) as well as community member feedback and participation. Performance accountability underlies strategic effort by way of consistent evaluation of our work while utilizing the Results Based Accountability Model. Our group(s) work together by leveraging the valuable resources and connections of each member. This multi-sector team approach allows CACH to carry out initiatives successfully which range from suicide prevention to family planning.

2019 ACHIEVEMENTS

Care Coordination Rates and Collaboration: The Burlington Health Service Area celebrated great success with a significant increase in the care management of the high- and very high-risk ACO patients. In March 2019, the HSA was at 2% care managed. We worked closely with our OneCare VT Clinical Consultant and with community partners (SASH, Age Well, Home Health and Hospice, UVMMC Medical group leadership) through two key meeting structures to create momentum and establish community wide workflows for the use of Care Navigator to capture the work. Members had increased accountability in reporting to the group and they celebrated successes. Outreach to each practice's care manager was provided to enhance their skills and understanding of the work. The relationships, communication structures, focused meetings and consistent messaging were key to the successes. We just celebrated 12% care management rate and we are on target to meet the 15% benchmark by the end of the calendar year.

CHT Social Work and Primary Care Integration: Further development of CHT Social Work integration with Nurse Care Managers in one of the larger primary care networks has been successful. We continue to meet as both leadership and clinicians to continue to evolve the collaboration. This initiative resulted in a coordinated system to provide care management to patients needing all levels of care management, but also a single system for providers to access to be efficient and easy to access.

ADDITIONAL FEATURED PROJECTS

MAT Billing: On January 1, 2019, the UVMMC MAT Team began a BlueCross, BlueShield of VT billing pilot. Leadership worked closely with our billing department to create a workflow to bill patients for their MAT service. Patients were made aware by their team members verbally and in written form explaining the change and offering financial support and resources. There has been 16-20 patients in this pilot group per month. A quarterly report is submitted on each patient that tracks 11 different data points, most of which can be pulled by running a report to track whether they have a diagnosis of HTN, or their blood pressure reading, whether they were

screened for tobacco use and had an annual AUDIT screening. A few require manual chart review to capture things like discussing a plan to address alcohol use if they screened positive on the AUDIT. Overall, although there is some labor intensity to the project, it has been positive and has brought in about $26,000 so far this year. It has also highlighted some process improvement areas for future general focus such as updating goals on a systematic basis and screening patients annually.

Quality Improvement: One practice in Chittenden County has been working with its Blueprint Quality Improvement Facilitator to improve chronic pain management. In addition to helping the practice make changes to prescribing protocols and office workflow, she identified an opportunity to provide patients with more tools to manage their pain. She reached out to the Blueprint Regional Self-Management Program Lead who then set up a chronic pain self-management program for the practice and sent an invitation to each patient the practice thought could benefit. The program, currently underway, is well attended and the practice anticipates working with the Blueprint to offer patients similar opportunities in the future.

Middlebury Health Service Area

Program Manager: Sylvie Choiniere

Middlebury By The Numbers

15,476	Primary care patients served at Blueprint practices in the past 2 years (based on insurance claims)
7.4	Community Health Team staff full time equivalents (FTEs)
3.5	Spoke staff FTEs
1.8	Women's Health Initiative staff FTEs
6	Self-management workshops held
27	Self-management workshop graduates
3,000+	Community Health Team encounters
117	Patients served in area Spokes (Medicaid only)

Middlebury Community Health Team

Middlebury Hospital Service Area Health Care Expenditures

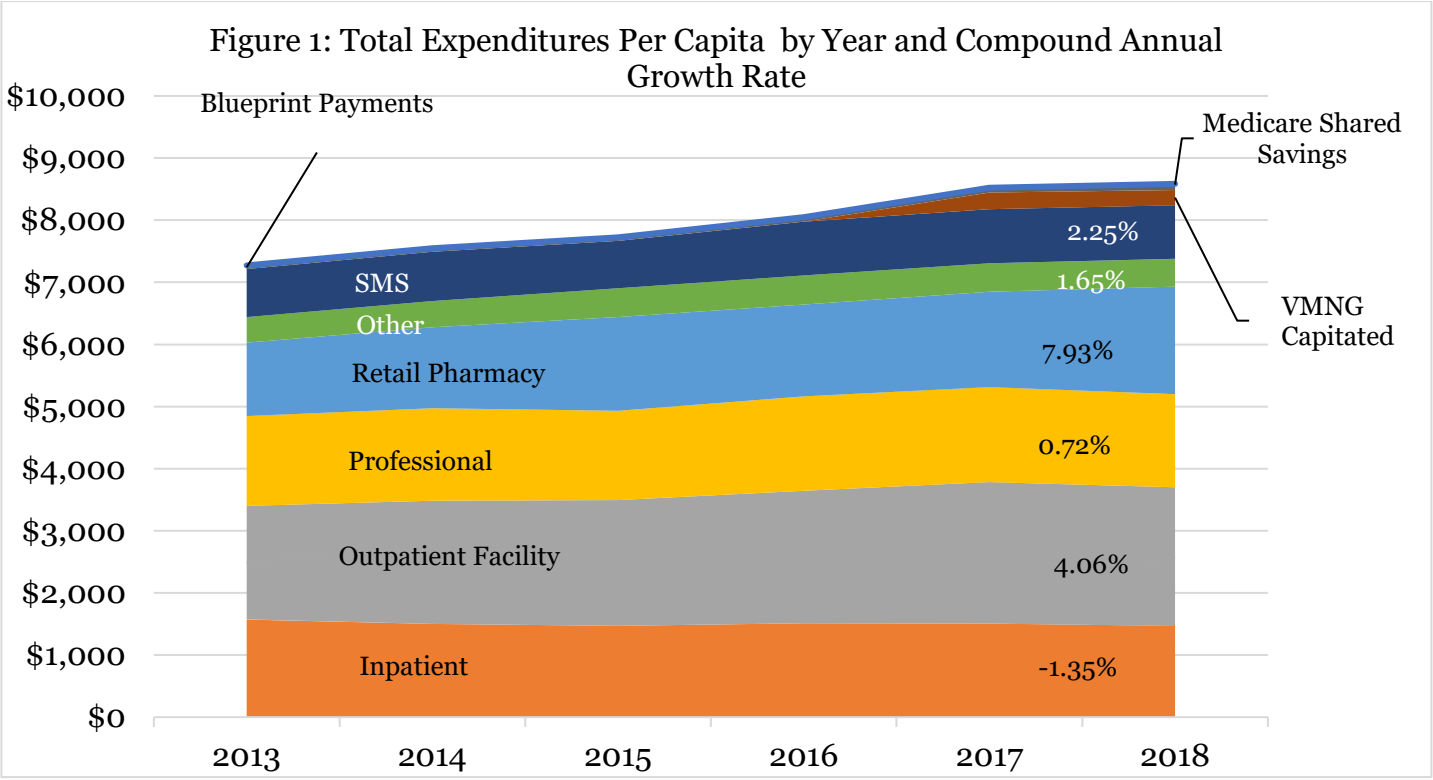


Figure 1: Presents unadjusted expenditures per capita by major category 2013-2018. The percentages on the right are the compounded annual growth across the time period. Every category showed increases except inpatient expenditures, which declined slightly.

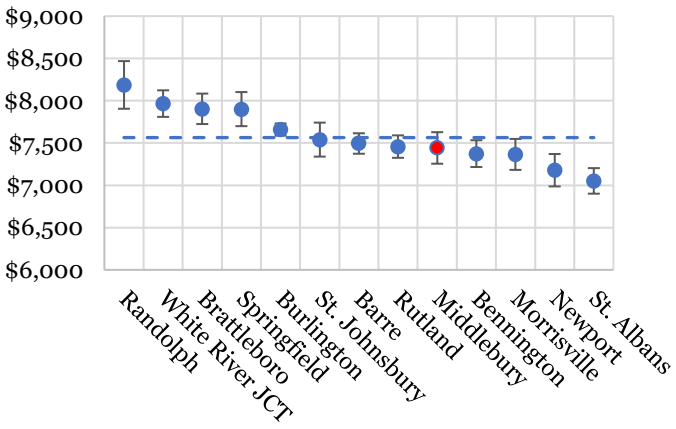


Figure 2: Presents annual risk-adjusted rates, including 95% confidence intervals. The blue dashed line indicates the statewide average. Middlebury is slightly below the statewide average.

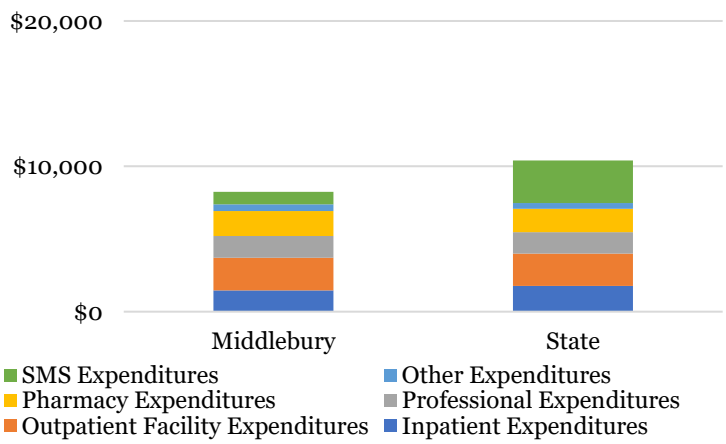


Figure 3: Presents 2018 non-adjusted rates, for the major categories of cost (as shown in Figure 1). Some services uniquely provided by Medicaid (e.g., case management, transportation) are reported separately as Special Medicaid Services (SMS). SMS expenditures in Middlebury are lower per capita than statewide.

MIDDLEBURY HEALTH SERVICE AREA

Name of area Accountable Community for Health or Community Collaborative Group:

COMMUNITY HEALTH ACTION TEAM (CHAT)

CHAT's mission is to identify the needs of the community and find innovative solutions to address them. The priorities for the CHAT group were identified through the annual data meeting that provided valuable statistics from birth to death. The group decided to focus on the low sense of optimism among youth by conducting a resiliency campaign to provide both youth and caregivers tools to help promote resiliency skills. The group aimed to expand on the resiliency campaign and is attempting to provide training and support around trauma-informed care. Funding has been secured to dedicate 10 hours/week to the trauma/resiliency efforts. Another priority was to engage the agencies involved with our elderly Vermonters. A concern that developed was the high levels of dehydration that discovered amongst our elderly Vermonters. Therefore, a subcommittee was formed to promote proper hydration and falls prevention for our elderly Vermonters. This is a collaborative effort with SASH, Area Agency on Aging, and residential programs. The group will be hosting their 3rd Annual Data Meeting in December 2019 to reassess priorities and develop a strategic plan.

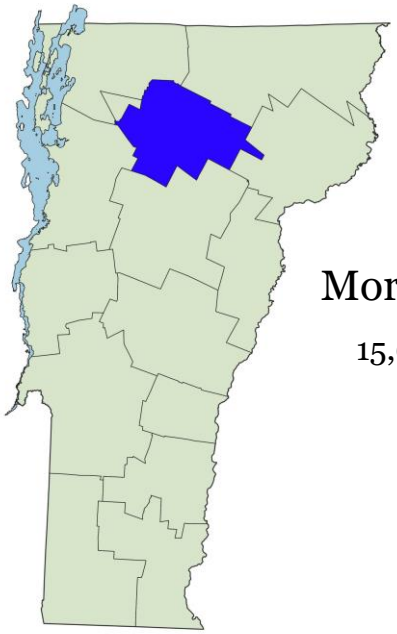
2019 ACHIEVEMENTS

Two major achievements in Addison County include efforts to address food insecurity and care coordination. UVMHN Porter Medical Center and Mountain Health Center, in collaboration with Addison County Relocalization Network and other agencies organized a Farmacy Share program for patients in Porter Primary Care Middlebury, Porter Pediatrics and Mountain Health Center (FQHC). This was a provider and CHT Registered Dietician referred program, in which participants who screened positive for food insecurity, diagnosed with diabetes, or would benefit from the program were encouraged to apply to the 12-week food share program. Collectively, 45 patients participated in the program, each received fresh fruits and vegetables from three local farms, as well as recipes and nutrition education from the CHT Registered Dietitians. This effort proved to be a major success and the surveys showed a significant increase in fresh food consumption and a solid foundation of knowledge and confidence on how to prepare these foods. Another successful effort included the implementation of embedded complex care managers in the primary care offices affiliated with UVMHN Porter Medical Center. These complex care managers have helped support our patients with various needs and connected them to resources that have positively impacted their health.

ADDITIONAL FEATURED PROJECTS

Agencies in Addison County have been working hard to bridge the gaps on various social determinants of health. One of the priorities identified was to increase immediate access to Medication Assistance Treatment in the Emergency Department. In collaboration with the ED, MAT staff, providers and Turning Point Center, the group has been working on a workflow to provide rapid access to MAT (RAM) in the ED. This strategy is scheduled to start in January 2020. Additionally, transportation has been identified as a constant barrier for patients and clients seeking both treatment and recovery. The Community Health Team has partnered with Addison County Transit Resources for the Rides to Wellness program to provide additional opportunities for transportation to residents lacking rides to appointments. This is also

scheduled to start in January 2020. Healthcare and transportation have been a major focus, but we are working to tackle whole person care through nutrition education combined with self-management diabetes prevention programs within schools. The CHT Registered Dietitians along with the Regional Coordinator are working to make programs more accessible and provide beneficial tools to participants that will help foster healthy lifestyles.



Morrisville Health Service Area

Program Manager: Hannah Ancel

Morrisville By The Numbers

15,686	Primary care patients served at Blueprint practices in the past 2 years (based on insurance claims)
5.5	Community Health Team staff full time equivalents (FTEs)
3.9	Spoke staff FTEs
1	Women's Health Initiative staff FTEs
2	Self-management workshops held
7	Self-management workshop graduates
7,939	Community Health Team encounters
200	Patients served in area Spokes (Medicaid only)

Morrisville Community Health Team

Morrisville Hospital Service Area Health Care Expenditures

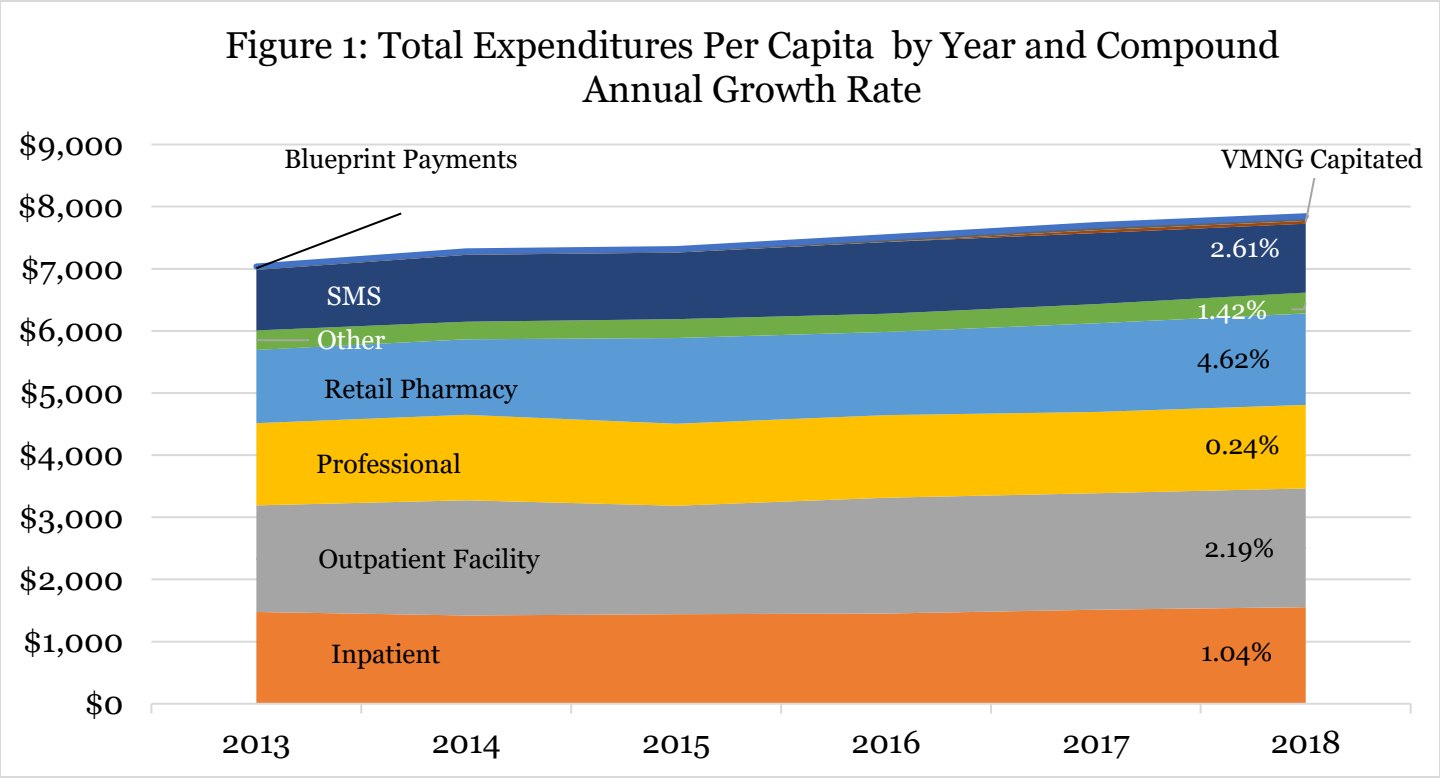


Figure 1: Presents unadjusted expenditures per capita by major category 2013-2018. The percentages on the right are the compounded annual growth across the time period. Every category showed growth over time, with pharmacy expenditures showing the greatest increases.

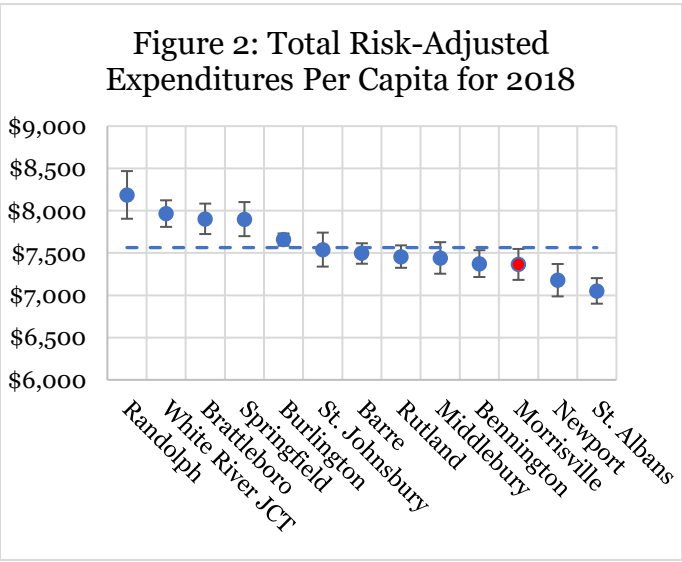


Figure 2: Presents annual risk-adjusted rates, including 95% confidence intervals. The blue dashed line indicates the statewide average. Morrisville is slightly below the statewide average.

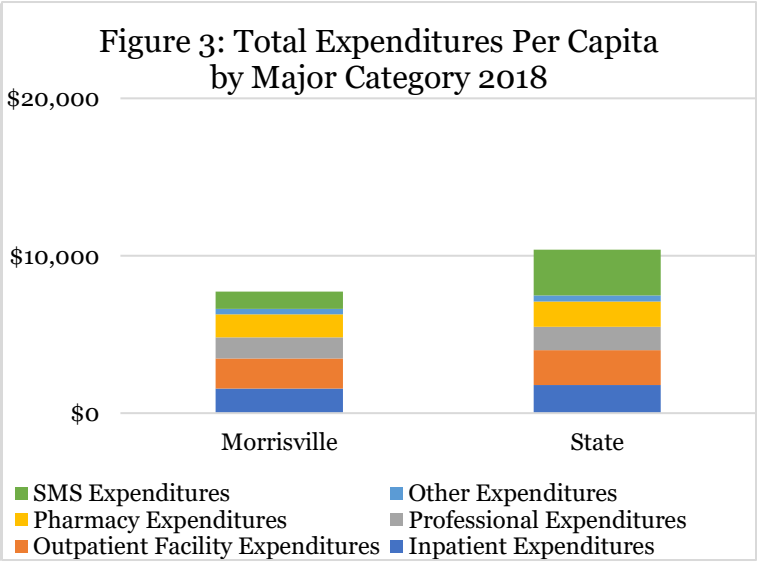


Figure 3: Presents 2018 non-adjusted rates, for the major categories of cost (as shown in Figure 1). Some services uniquely provided by Medicaid (e.g., case management, transportation) are reported separately as Special Medicaid Services (SMS). SMS expenditures in Morrisville are substantially lower per capita than

MORRISVILLE HEALTH SERVICE AREA

Name of area Accountable Community for Health or Community Collaborative Group:

LAMOILLE UNIFIED COMMUNITY COLLABORATIVE

Our Lamoille UCC involves 24 health care and human service organizations & programs. We meet monthly and have a steering committee that helps prioritize efforts in meeting the goals for the group. The leadership group of the UCC meets quarterly and approves initiatives recommended by the UCC. Broadly, we work together to identify social determinants of health needs in our community. Our goal is to have universal screening in our appropriate organizations that identifies the following: mental & physical health; financial, housing, & food stability; as well as safety issues. Our group finds ways, such as the above screening, to integrate care more effectively. This year, our two focus areas involved initiatives related to Zero Suicide and Substance Misuse screening. This allowed us to direct the group's energies toward addressing two critical issues in our community.

2019 ACHIEVEMENTS

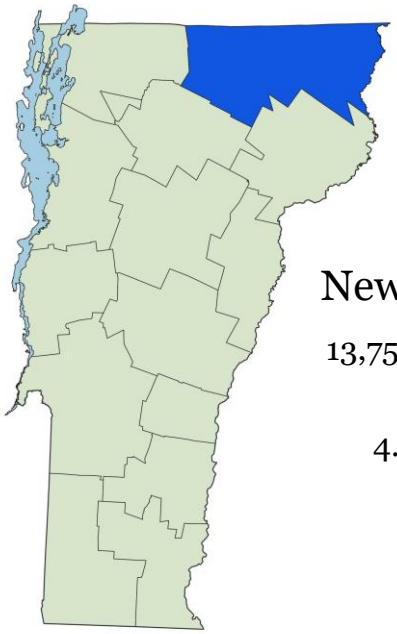
In May of 2019 the UCC voted on and approved two focus areas, Zero Suicide and substance misuse. We identified two goals for each. For substance misuse we are working on a systematic process to distribute printed materials to all the health and human service organizations in our HSA (including schools). Our second goal in this area is to increase substance misuse screenings in participating organizations in the UCC.

For Zero Suicide we are working on increasing the amount and locations of depression screening performed in identified organizations as well as increasing the number of staff trained in the Columbia and CAMS methods. One outcome of this effort is that a high percentage of the ED staff are trained in the Columbia method.

As part of the structure to implement the goals for Zero Suicide and substance misuse, two existing groups were identified to become Community Action Networks (CANs) to track and monitor efforts throughout our HSA. Zero Suicide is led by the Lamoille County Mental Health Community Zero Suicide Group, and substance misuse is led by Upstream Lamoille. Both groups are made up of multiple organizations in our HSA with professional representation from law enforcement, Copley Hospital, prevention specialists, MAT team, Recovery Center, Primary Care, CHT, Behavioral Health, as well as patients and families. Initial data from organizations that are doing the screenings show that the two primary referral reasons are for mental health (including depression) & substance misuse. This has pointed out that our focus areas are on track.

ADDITIONAL FEATURED PROJECTS

1. We are developing a new online self-management programs for both diabetes and tobacco.
2. Our community is now participating in OneCare for Medicaid, and the UCC focus areas dovetail nicely with some of the identified quality measures.
3. Three PCMHs are designing workflow improvements around hospital and ED discharges and follow-up care as well as diabetic patients and newly diagnosed hyper-tension (HTN) patients.



Newport Health Service Area

Program Manager: Julie Riffon

Newport By The Numbers

13,754	Primary care patients served at Blueprint practices in the past 2 years (based on insurance claims)
4.3	Community Health Team staff full time equivalents (FTEs)
0	Spoke staff FTEs
0	Women's Health Initiative staff FTEs
1	Self-management workshops held
8	Self-management workshop graduates
5076	Community Health Team encounters (1563 face-to-face, 3513 other contacts)
0	Patients served in area Spokes (Medicaid only) * patients are served in the St. Johnsbury Hub

Newport Community Health Team

Newport Hospital Service Area Health Care Expenditures

Figure 1: Total Expenditures Per Capita by Year and Compound Annual Growth Rate

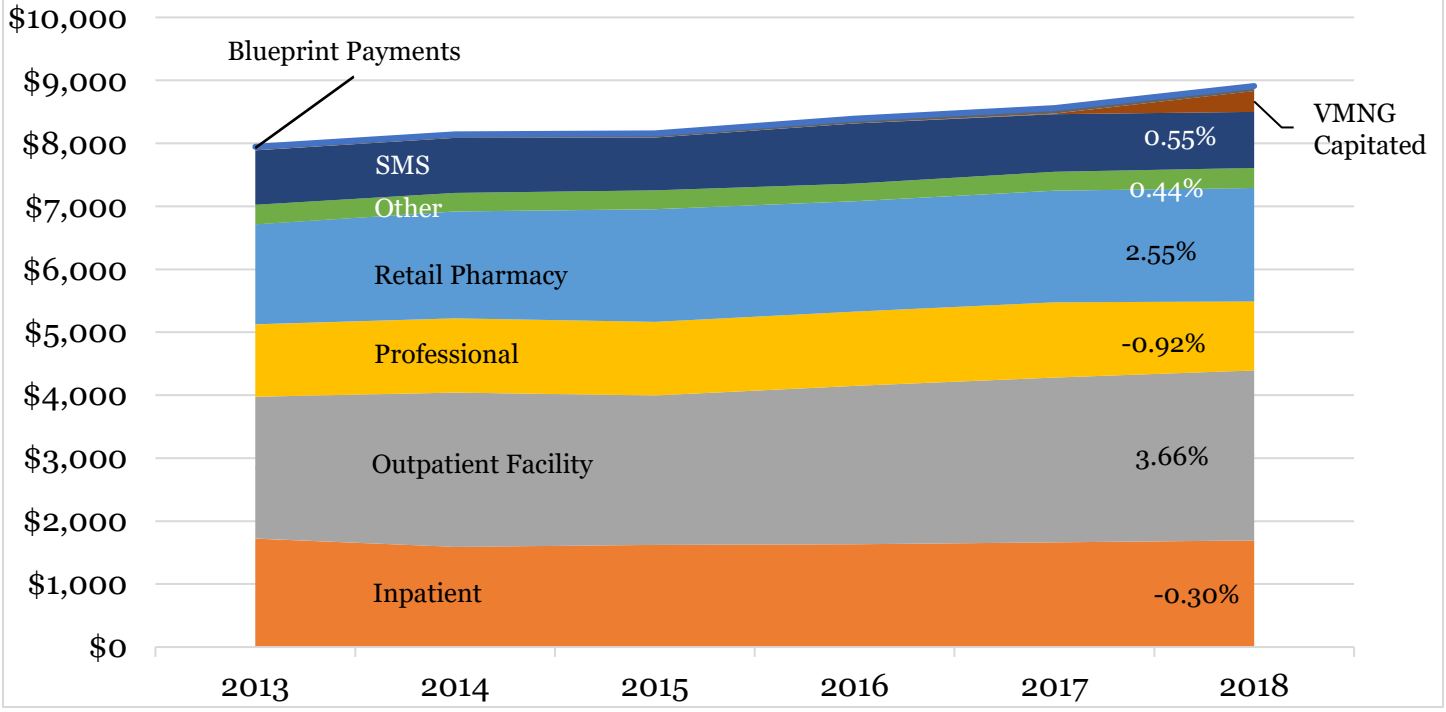


Figure 1: Presents unadjusted expenditures per capita by major category 2013-2018. The percentages on the right are the compounded annual growth across the time period. Inpatient and Professional expenditures declined slightly, while all other categories showed growth over time.

Figure 2: Total Risk-Adjusted Expenditures Per Capita for 2018

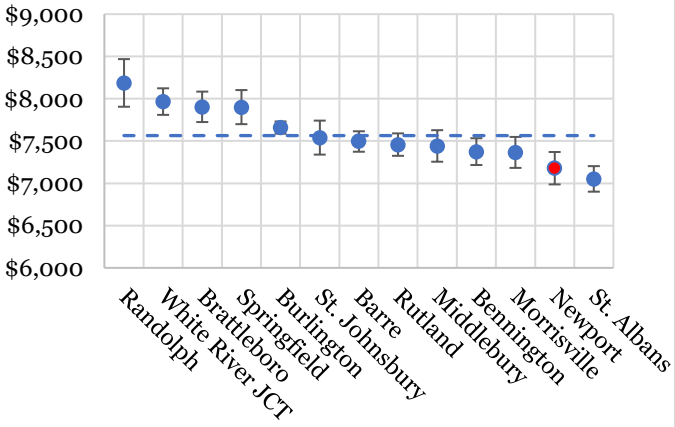


Figure 2: Presents annual risk-adjusted rates, including 95% confidence intervals. The blue dashed line indicates the statewide average. Newport is below the statewide average.

Figure 3: Total Expenditures Per Capita by Major Category 2018

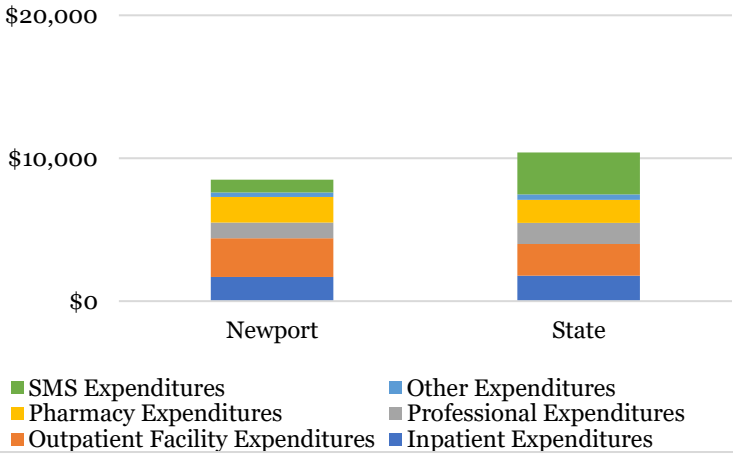


Figure 3: Presents 2018 non-adjusted rates, for the major categories of cost (as shown in Figure 1). Some services uniquely provided by Medicaid (e.g., case management, transportation) are reported separately as Special Medicaid Services (SMS). SMS expenditures in Newport are lower per capita than statewide, while outpatient facility expenditures are slightly higher.

NEWPORT HEALTH SERVICE AREA

Name of area Accountable Community for Health or Community Collaborative Group:

UPPER NORTHEAST KINGDOM COMMUNITY COUNCIL (UNEKCC)

Mission/Vision: We are committed to significantly improve the health & well-being of the people in Orleans & northern Essex counties. Through innovation & collaborative effort, we build strong communities supporting healthy & prosperous lives in Orleans and northern Essex counties

Membership: The CEOs/designees from NCH, NEKCA, NKHS, No. Counties Health Care, RuralEdge, Newport District VDH, OEVNA & Hospice, Council on Aging & the supervisory unions serving the HSA

Common agenda: Our next generation, whose dreams are community supported, is VT's healthiest and most successful generation

2020 accomplishments: continue to adapt to transitions in leadership among key member organizations; hosted a well-attended Community Forum to determine priorities & 2020 plan to move forward

2019 ACHIEVEMENTS

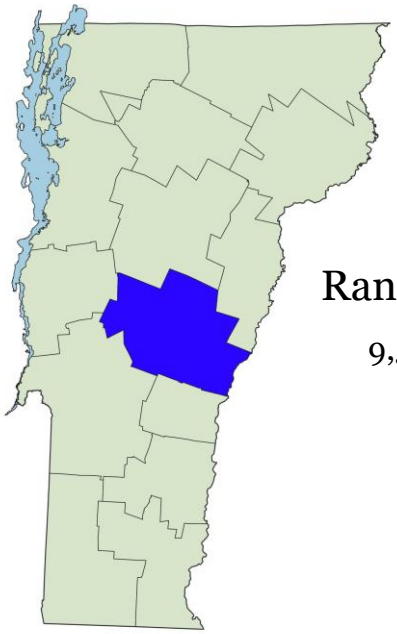
In 2019, Newport's Blueprint Team made significant differences in our community members lives by providing 2069 Implementation Strategies activities linked to the Priority Health Concerns identified in NCH's Community Health Needs Assessment, including:

- Supporting mental wellness & a substance free lifestyle: The Team connected 532 people to mental health counseling, psychiatry services embedded within primary care, LADC, inpatient and/or community-based treatment resources
- Supporting a tobacco free lifestyle: The Team referred/provided 87 people with individual/group tobacco cessation counseling
- Supporting healthy eating & physical activity: This included 409 dietician encounters in primary care/pediatric practices at no charge to the individuals. Also, the Blueprint CHT coordinated the third annual HealthCare Shares program with 85 families participated
- Supporting access to medical and oral health services: The Team connected 272 people with transportation to medical appointments, 16 to dental appointments and 16 to VCCI program
- Supporting Aging in Place: connected 31 people to SNF Rehab Programs,30 to local VNA and 59 to the Council on Aging

The CHT focused on increasing Care Navigator documentation of care coordination provided to OCV's Medicaid High Risk/Very High-Risk Medicaid attributed lives and became a leader in Vermont in the per centage of this documentation

We continued to improve the five day/week psychiatry services embedded in the primary care practice by introducing new psychiatry referrals at the time of the first visit to the CHT LICSW in order to provide increased coordination of care

Our pediatric & two primary care practices successfully together submitted & achieved annual NCQA PCMH recognition. This was the result of significant efforts in standardization of processes, workflows and quality initiatives.



Randolph Health Service Area

Program Manager: Patrick Clark

Randolph By The Numbers

9,563	Primary care patients served at Blueprint practices in the past 2 years (based on insurance claims)
4.9	Community Health Team staff full time equivalents (FTEs)
2.2	Spoke staff FTEs
0.5	Women's Health Initiative staff FTEs
30	Self-management workshops held
185	Self-management workshop graduates
820	Community Health Team referrals
89	Patients served in area Spokes (Medicaid only)

Randolph Community Health Team

Randolph Hospital Service Area Health Care Expenditures

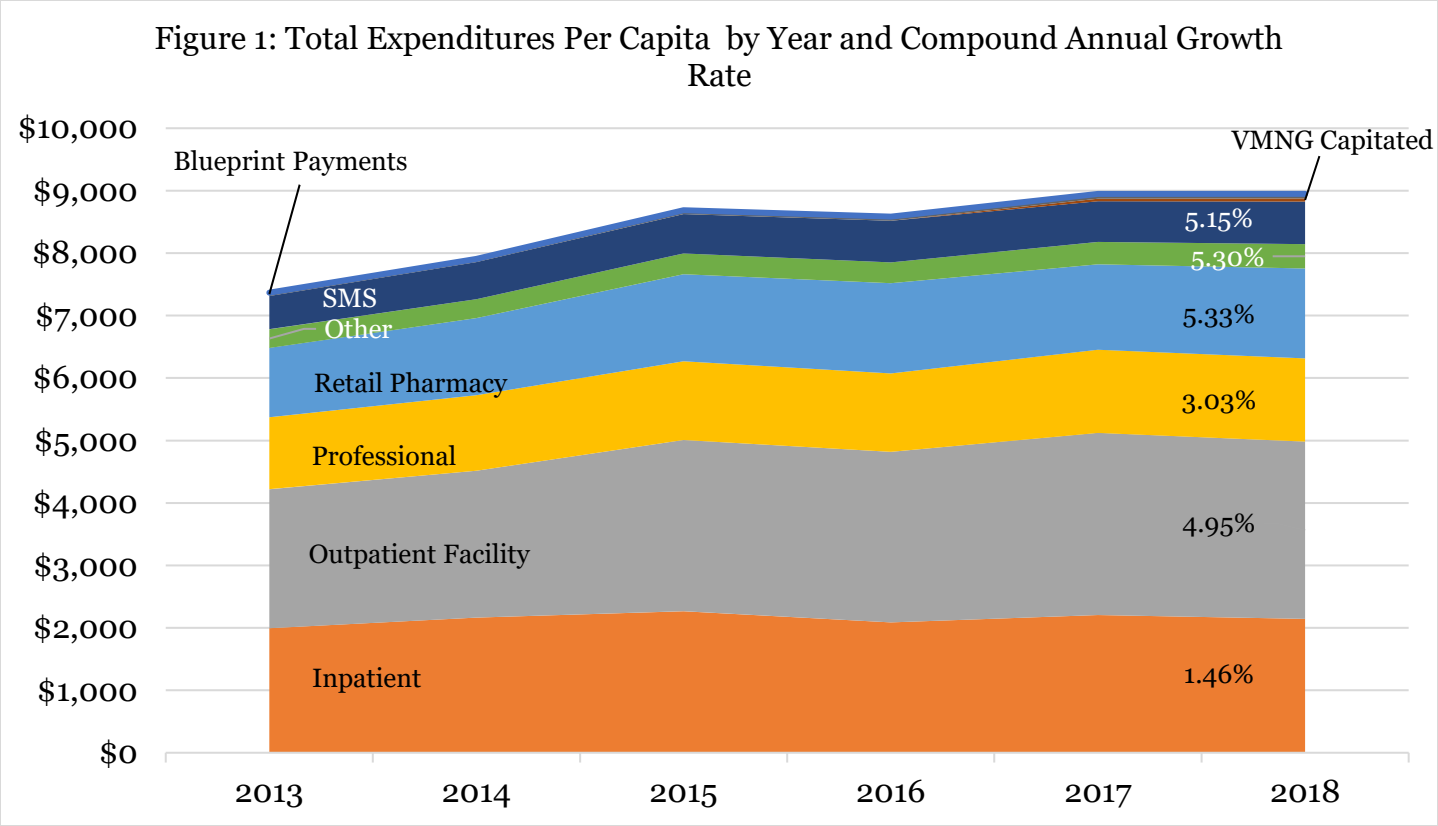


Figure 1: Presents unadjusted expenditures per capita by major category 2013-2018. The percentages on the right are the compounded annual growth across the time period. Every category showed increases, with growth in Pharmacy and 'Other Expenditures' exceeding the other categories.

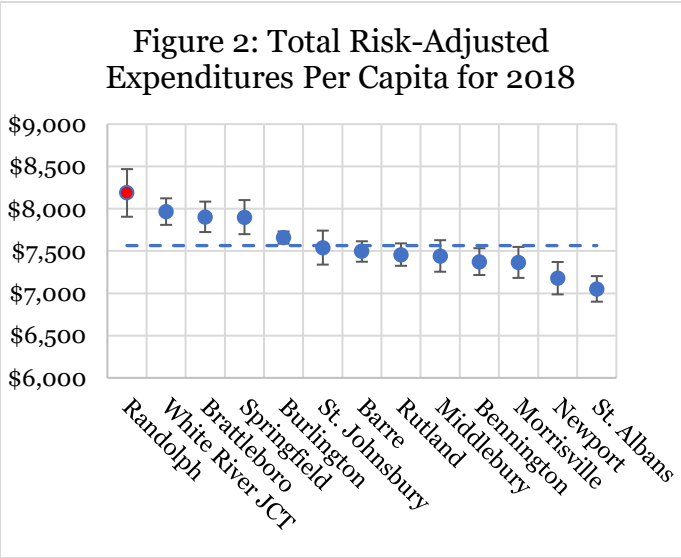


Figure 2: Presents annual risk-adjusted rates, including 95% confidence intervals. The blue dashed line indicates the statewide average. Randolph is significantly above the statewide average.

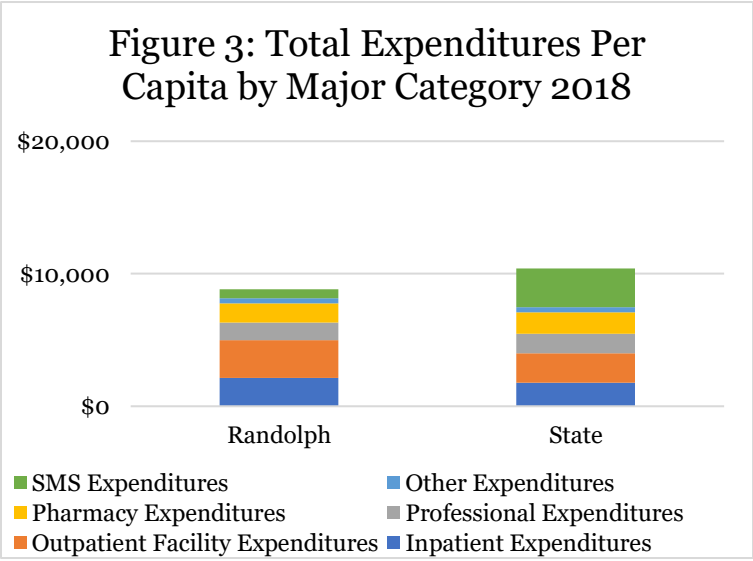


Figure 3: Presents 2018 non-adjusted rates, for the major categories of cost (as shown in Figure 1). Some services uniquely provided by Medicaid (e.g., case management, transportation) are reported separately as Special Medicaid Services (SMS). SMS expenditures in Randolph are lower per capita than statewide.

RANDOLPH HEALTH SERVICE AREA

Name of area Accountable Community for Health or Community Collaborative Group:

RANDOLPH EXECUTIVE COMMUNITY COUNCIL (RECC)

The RECC addresses population and public health in our area, through the identification of issues and measures which are most relevant, applicable, and challenging for our community members. We utilize qualitative and quantitative data to learn how we can best serve all segments of our population. RECC members chose high emergency department utilization and nutrition as priority areas over this past year. More recently, a prevention workgroup formed which involves individuals that are leading the RiseVT and 3-4-50 initiatives in our area.

2019 ACHIEVEMENTS

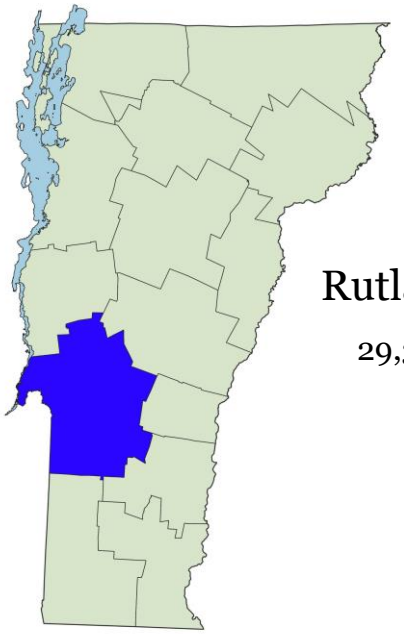
Rapid Access to Medication Assisted Treatment (RAM) – Over the past year, we have been participating in the RAM initiative being led by the Central Vermont Medical Center Emergency Department (ED). The Gifford ED recently implemented RAM and the ED providers are now able to initiate MAT and refer patients to community MAT services within 72 hours of an ED visit.

Expansion of Shared Care Team Meetings and Care Management for High-Risk Individuals - Gifford began participating with One Care Vermont (OCV) in January 2019, which has changed our Community Health Team's (CHT) composition and role over the last year. We hired two CHT Nurse Care Managers to care manage the OCV high and very high risk attributed lives. "Care managed" is defined by OCV as having a lead care coordinator assigned and a shared care plan with at least two goals and two tasks per goal documented. To date, 16% of our OCV high and very high risk attributed lives are care managed. In addition to holding shared care team meetings with OCV collaborating organizations, the CHT continues working on shared care plans with community partners for non-OCV individuals who are considered medically complex. For example, we meet with Support and Services at Home (SASH) monthly to collaborate on Medicare patients receiving SASH services.

ADDITIONAL FEATURED PROJECTS

Diabetes Prevention and Treatment - All Gifford primary care practices are participating in the Vermont Department of Health diabetes initiative, which involves the development and implementation of protocols for pre-diabetes and diabetes treatment across all practices. In addition to protocol implementation, there is a focus on increasing referrals to our Diabetes Educator, Diabetes Prevention Programs, and Diabetes Self-Management Programs. We are also working with our community partners such as SASH and the Clara Martin Center to ensure those organizations have the most current clinical data on mutual individuals managing chronic diseases.

Zero Suicide Initiative – Gifford implemented the use of the Columbia Suicide Severity Rating Scale (C-SSRS) in all practice and hospital settings over the past year. This involved building the C-SSRS in each of our electronic health records and training medical staff on the use of the C-SSRS. Staff members were also trained on the importance of follow-up care, connecting patients with community resources, and reducing access to lethal means.



Rutland Health Service Area

Program Manager: Kirk Postlewaite

Rutland By The Numbers

29,340	Primary care patients served at Blueprint practices in the past 2 years (based on insurance claims)
17	Community Health Team staff full time equivalents (FTEs)
9.8	Spoke staff FTEs
1.5	Women's Health Initiative staff FTEs
26	Self-management workshops held
76	Self-management workshop graduates
345	Patients served in area Spokes (Medicaid only)

Rutland Community Health Team

Rutland Hospital Service Area Health Care Expenditures

Figure 1: Total Expenditures Per Capita by Year and Compound Annual Growth Rate

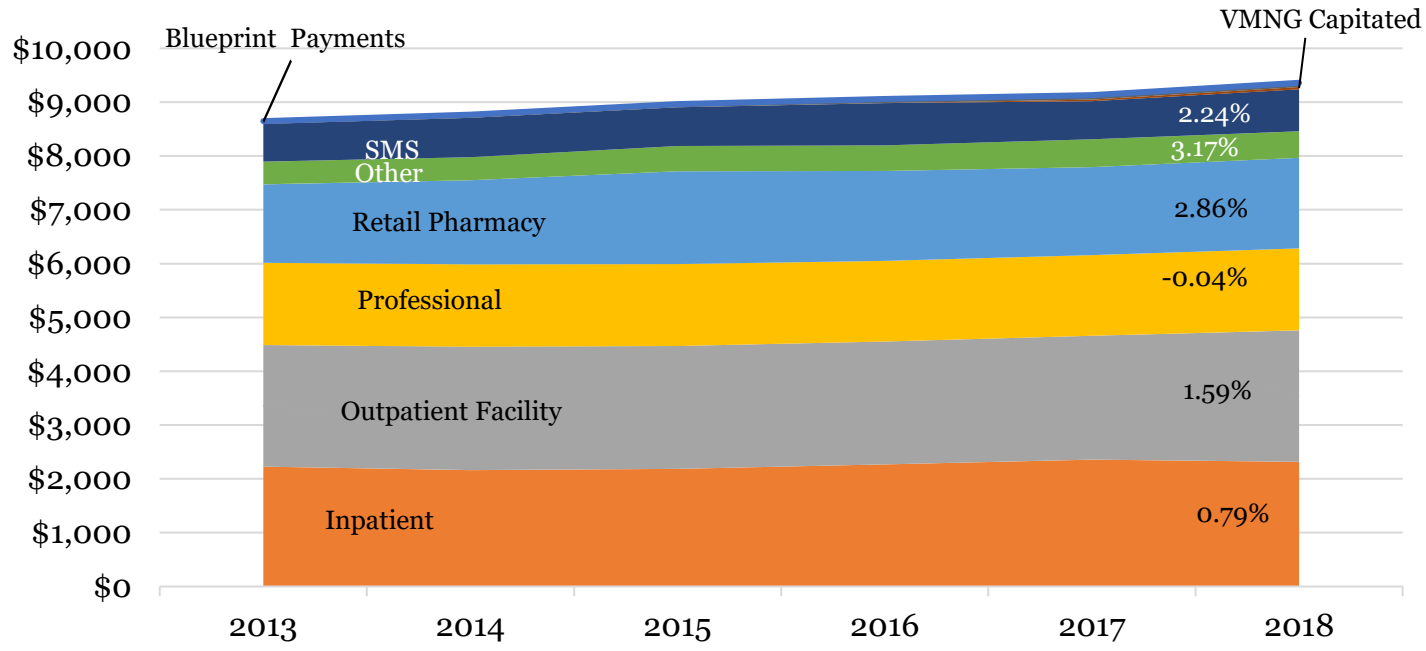


Figure 1: Presents unadjusted expenditures per capita by major category 2013-2018. The percentages on the right are the compounded annual growth across the time period. Every category showed increases except Professional, which declined slightly.

Figure 2: Total Risk-Adjusted Expenditures Per Capita for 2018

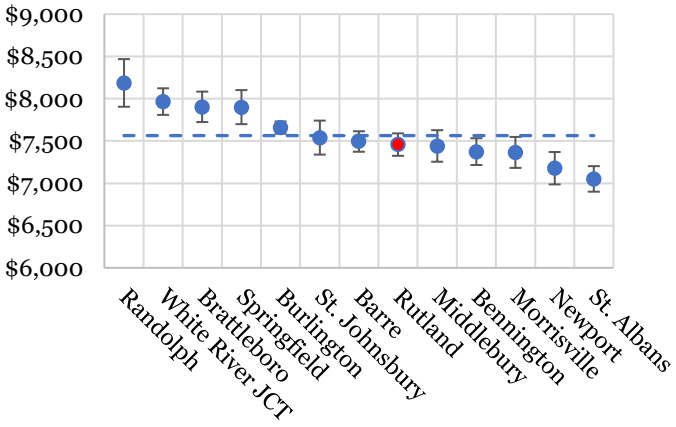


Figure 2: Presents annual risk-adjusted rates, including 95% confidence intervals. The blue dashed line indicates the statewide average. Rutland is slightly below the statewide average.

Figure 3: Total Expenditures Per Capita by Major Category 2018

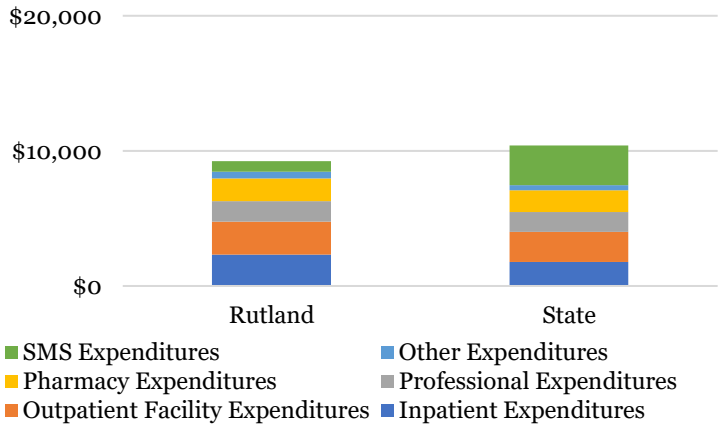


Figure 3: Presents 2018 non-adjusted rates, for the major categories of cost (as shown in Figure 1). Some services uniquely provided by Medicaid (e.g., case management, transportation) are reported separately as Special Medicaid Services (SMS). SMS and Outpatient Facility expenditures are lower per capita in Rutland than statewide.

RUTLAND HEALTH SERVICE AREA

Name of area Accountable Community for Health or Community Collaborative Group:

RUTLAND COMMUNITY COLLABORATIVE

The Rutland Community Collaborative is committed to improve the overall health of the Rutland community through appropriate utilization and access of healthcare services. There are approximately between 25 and 30 community organizations who participate and are engaged in the collaborative. This year the Education & Engagement community took on the larger collaborative goal of reducing the prevalence of Sepsis in the community and created a community wide Sepsis campaign to bring about awareness. A new RCC dashboard includes data from the hospital and the community skilled nursing facilities.

2019 ACHIEVEMENTS

Complex Care Coordination – The Community Health Team facilitates the Community Centered Care Committee to support a multi-agency approach to assist patients to access appropriate care and identify collaborative interventions. Along with the Community Health Team, Community Health Centers (Primary Care), Rutland Mental Health, Rutland Regional Medical Center, SASH, Southern Vermont Council on Aging, and The Visiting Nurse Association and Hospice of the Southern Region have participated in this collaborative effort. The goal of this committee is to not only improve agency collaboration and access to appropriate care, but also allow patients to attend and participate in the meeting.

Self-Management – Great success was made with the Self-Management Programs and Diabetes Prevention Program. Three Diabetes Prevention sessions were offered and Chronic Disease, Chronic Pain, and Diabetes Self-Management programs were also successfully completed. In addition to the success of these self-management programs, new leaders have been trained, including for the Wellness Recovery Action Plan program, which will allow for even greater success in 2020.

More than 30 Tobacco Cessation workshops were offered in 2019, with 2 Tobacco Treatment Specialists trainings and 2 Fresh Start leader trainings offered. In addition to the community offerings, Rutland Regional Medical Center focused on providing evidence-based cessation support to active in-patients who reported tobacco/e-cigarette use. The success of this effort included EMR changes, physician and nurse scripting, education, as well as Nicotine Replacement therapy offering regardless of insurance coverage.

The Wellness Recovery Action Plan (WRAP) program will also resume in the Rutland area within the next few months, as several individuals in the Rutland community have completed the leader training.

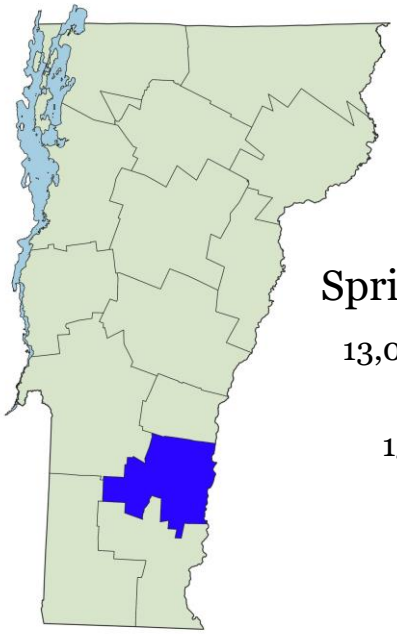
ADDITIONAL FEATURED PROJECTS

The Community Health Team continues to provide Care Coordination for Patient Centered Medical Homes and Rutland Community at large. Whether it's to assist pediatric patients and families to access the out of area specialty care, supporting an older adult in transitioning into an Assisted Living setting, or securing housing for an individual experiencing homelessness The

Community Health Team provides a patient-centered approach in assisting patients and families to access the resources and supports needed to meet their identified needs.

The Rutland Health Service area is also actively engaged with OneCare and the use of Shared Care Plans. In October the decision was made to transition from using the Electronic Medical Record of Rutland Regional Medical Center as the platform for Shared Care Plans to Care Navigator. The goal is to begin utilizing Care Navigator by December 1, 2019, with multiple trainings underway for Community Health Centers, Rutland Regional Medical Center along with Rutland Mental Health, SASH, VNA, Bayada, and SVCOA.

Another project for the Rutland Health Service Area is the Rutland Safe Suicide Care Project. The Vermont Suicide Prevention Center, managed by the Center for Health and Learning (CHL), the Rutland Regional Medical Center (RRMC), Rutland Mental Health Services (RMHS) and Community Health Center of the Rutland Region are implementing a 3-year suicide prevention project targeting vulnerable populations in the Rutland area. The Rutland Safe Suicide Care Project will reduce barriers to accessing suicide safe care in the Rutland area by identifying system gaps and opportunities, building infrastructure for a collaborative, integrated system of care, and improving knowledge and skills among behavioral health providers, primary care practitioners, and hospital inpatient and Emergency Departments in the Rutland area. The project will target residents in Rutland County, focusing on reaching residents through three mediums: Mental Health Services; Primary and Preventive Care Services; and Emergency Departments.



Springfield Health Service Area

Program Manager: Tom Dougherty

Springfield By The Numbers

13,039	Primary care patients served at Blueprint practices in the past 2 years (based on insurance claims)
13.7	Community Health Team staff full time equivalents (FTEs)
1.6	Spoke staff FTEs
1	Women's Health Initiative staff FTEs
16	Self-management workshops held
75	Self-management workshop graduates
152	Patients served in area Spokes (Medicaid only)

Community Health Team encounters (10/2018 – 09/2019)

450	Individuals established with primary care via CHT
1,126	Diabetes education encounters with CHT providers
686	Ride assistance provided to health and wellness services

Springfield Community Health Team

Springfield Hospital Service Area Health Care Expenditures

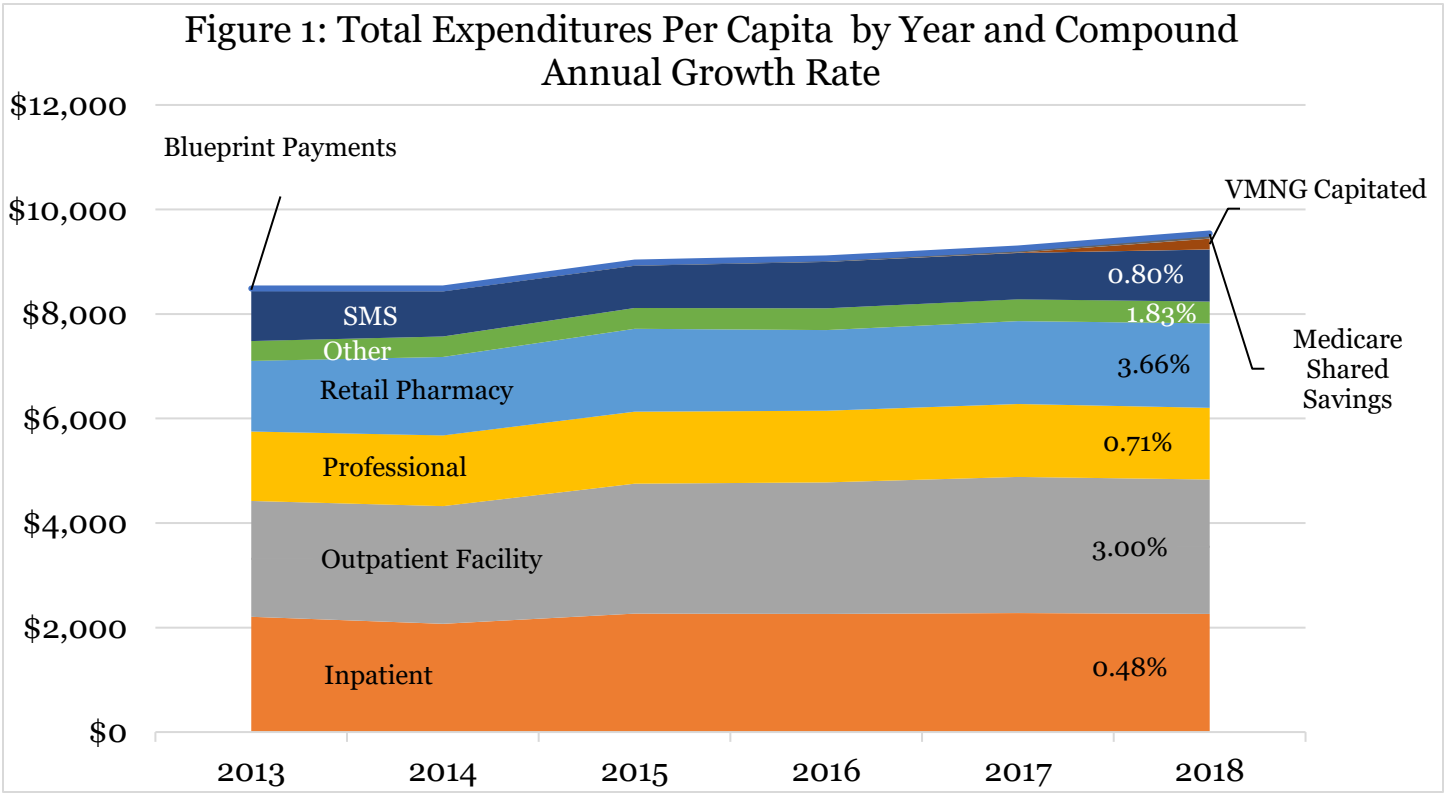


Figure 1: Presents unadjusted expenditures per capita by major category 2013-2018. The percentages on the right are the compounded annual growth across the time period. Every category showed increases, with growth in Pharmacy the most significant.

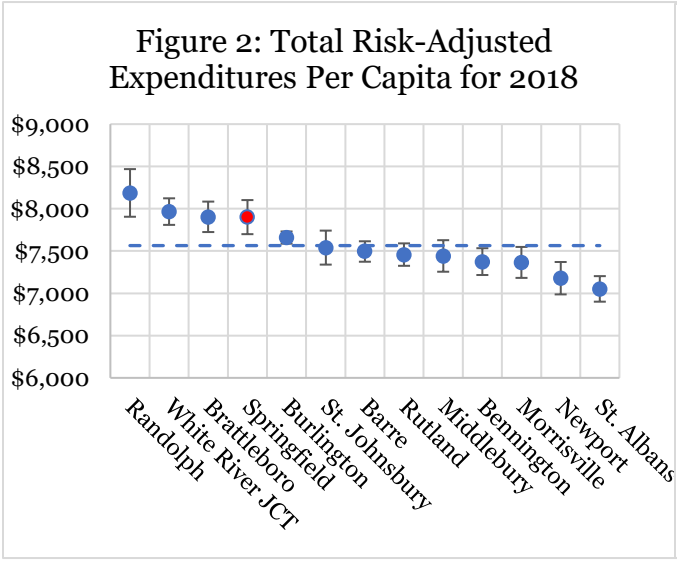


Figure 2: Presents annual risk-adjusted rates, including 95% confidence intervals. The blue dashed line indicates the statewide average. Springfield is above the statewide average.

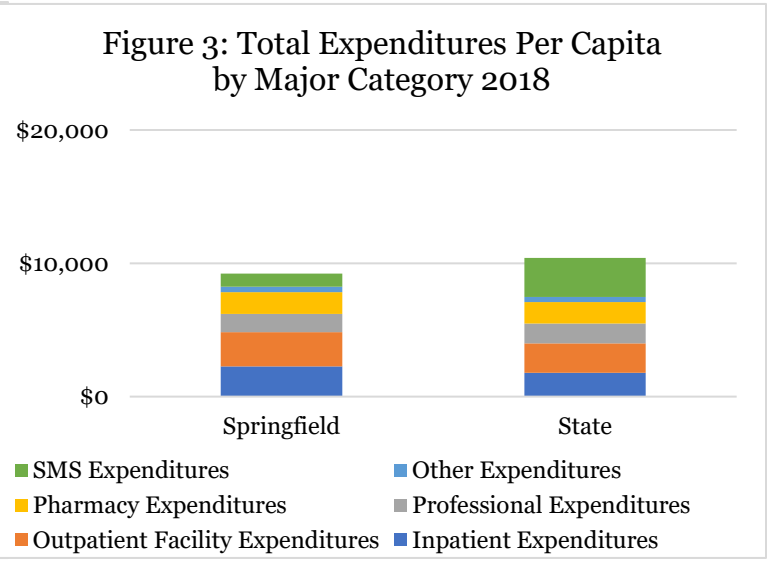


Figure 3: Presents 2018 non-adjusted rates, for the major categories of cost (as shown in Figure 1). Some services uniquely provided by Medicaid (e.g., case management, transportation) are reported separately as Special Medicaid Services (SMS). SMS expenditures in Springfield are lower per capita than statewide.

SPRINGFIELD HEALTH SERVICE AREA

Name of area Accountable Community for Health or Community Collaborative Group:

SPRINGFIELD HSA COMMUNITY COLLABORATIVE

The Springfield HSA Community Collaborative brings community providers of health, wellness and social services together to discuss goals and to make decisions to work towards the goal of health and well-being for our community. Nine workgroups address priority issues identified in our community health needs assessment including improving access to key services such as substance use treatment, behavioral health services, and oral health services and women's health services, improving coordination of care across organizations and sectors and preventing chronic conditions through the development of a more vibrant, resilient and supportive community. In 2019 these efforts resulted in expanded and streamlined access to these services, greater awareness of resources in the community and closer collaboration in meeting community needs. 2019 also saw the completion of a tri-annual Community Health Needs Assessment with input from all sectors of the community. The findings will guide the work of the Community Collaborative over the next three years.

2019 ACHIEVEMENTS

Working closely with primary care practices and emergency department providers, Blueprint-supported staff including our Community Health Team and clinical care coordinators launched a major initiative to implement **Screening Brief Intervention and Navigation to Services** (SBINS) with primary care sites, the ED and CHT services in 2019. With the intention of better informing care delivery and identifying barriers to care including needs associated with social determinants of health, our team drew upon our experience implementing SBINS through the Women's Health Initiative to develop workflows and best practices for all primary care sites. In February 2019 SBINS screening was introduced for all patients ages 15-44 and in July 2019 for patients seen in the Emergency Department. Hunger Vital Signs were also included at intake for individuals requesting transportation assistance. The SBINS roll out complemented our ongoing development of care coordination services and has led to improvements in connecting individuals with needed services.

2019 also saw a significant increase in participation in self-management programs, thanks to recruitment of additional facilitators, collaboration with community partners and the resulting expansion of class locations and times available to community members.

ADDITIONAL FEATURED PROJECTS

High ED Utilization. Building on the continuing development of our care coordination services and employment of core skills, care teams focused on ACO attributed patients and others with multiple ER visits and hospital admissions. Case reviews including a wide range of community partners proved instrumental in developing and implementing shared care plans and reducing frequent ED visits.

Diabetes Panel Management. With a CHT structure to support robust panel management, blood glucose control was one measure chosen for plan-do-study-act (PDSA) cycles for PCMH recognition which fueled six different tests of change. Supporting these efforts were onsite learning sessions with Matthew Gilbert, DO, MPH, and the successful transition of multiple patients to GLP-1 RA treatments resulting in improved performance.

Care Coordination. The CHT provided essential support for the provision of clinical care coordination for high-risk patients with chronic conditions, especially in the implementation of the OneCare model, including user support for Care Navigator and direct training in Core Skills.

St. Albans Health Service Area

Program Managers: Candace Collins

St. Albans By The Numbers

21,325	Primary care patients served at Blueprint practices in the past 2 years (based on insurance claims)
12.5	Community Health Team staff full time equivalents (FTEs)
12.3	Spoke staff FTEs
2	Women's Health Initiative staff FTEs
8	Self-management workshops held
36	Self-management workshop graduates
14,429	Community Health Team encounters
506	Patients served in area Spokes (Medicaid only)

St. Albans Community Health Team

St. Albans Hospital Service Area Health Care Expenditures

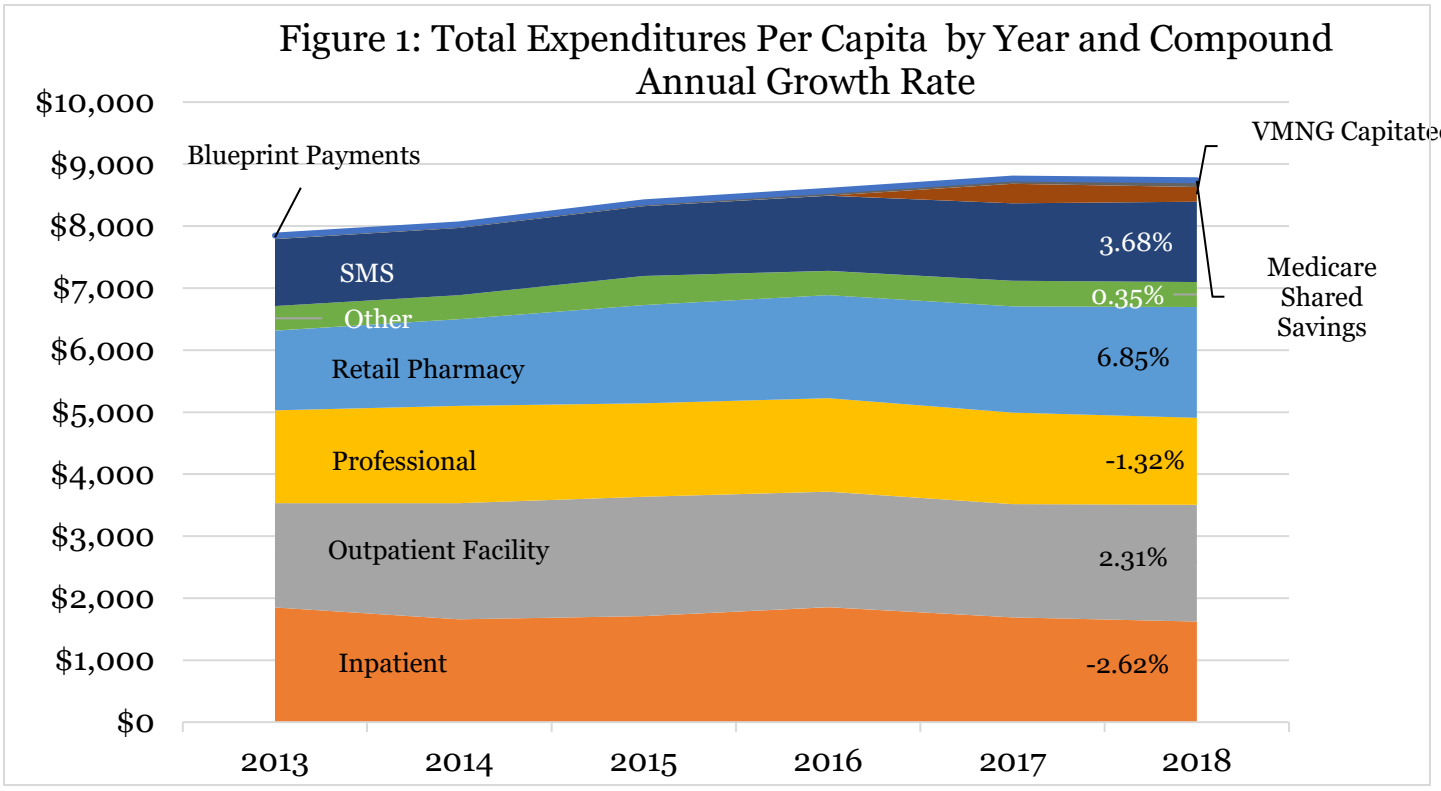


Figure 1: Presents unadjusted expenditures per capita by major category 2013-2018. The percentages on the right are the compounded annual growth across the time period. Every category showed increases except inpatient and professional expenditures, which declined.

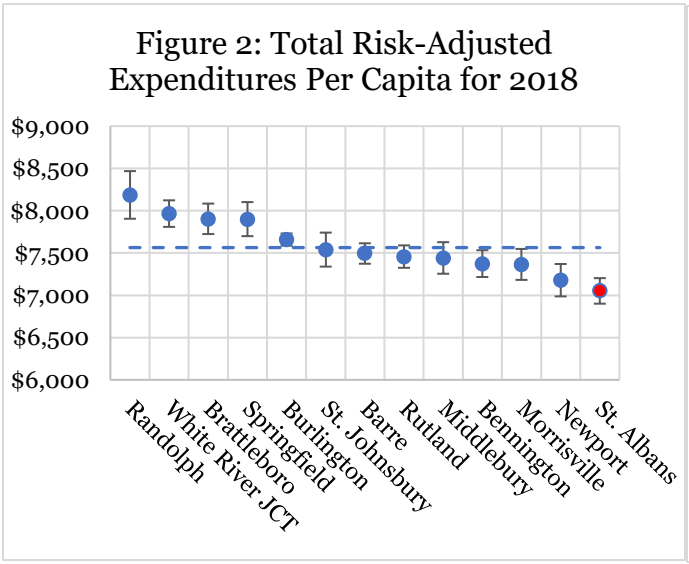


Figure 2: Presents annual risk-adjusted rates, including 95% confidence intervals. The blue dashed line indicates the statewide average. St. Albans is below the statewide average.

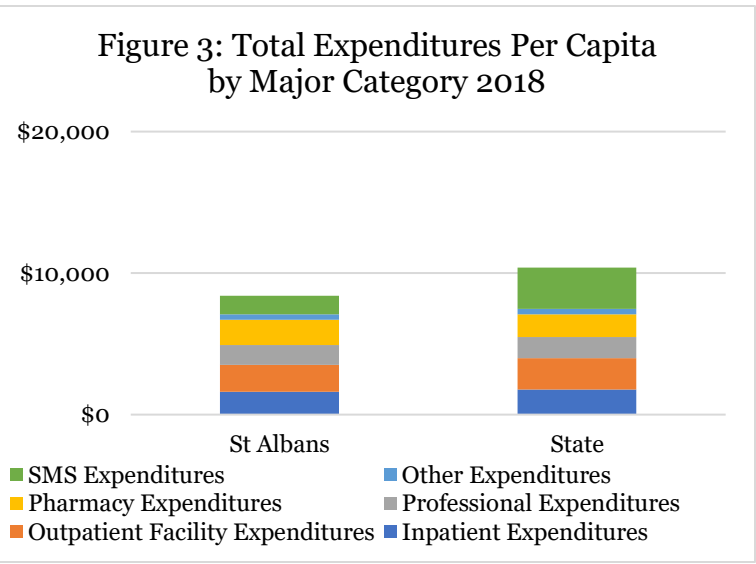
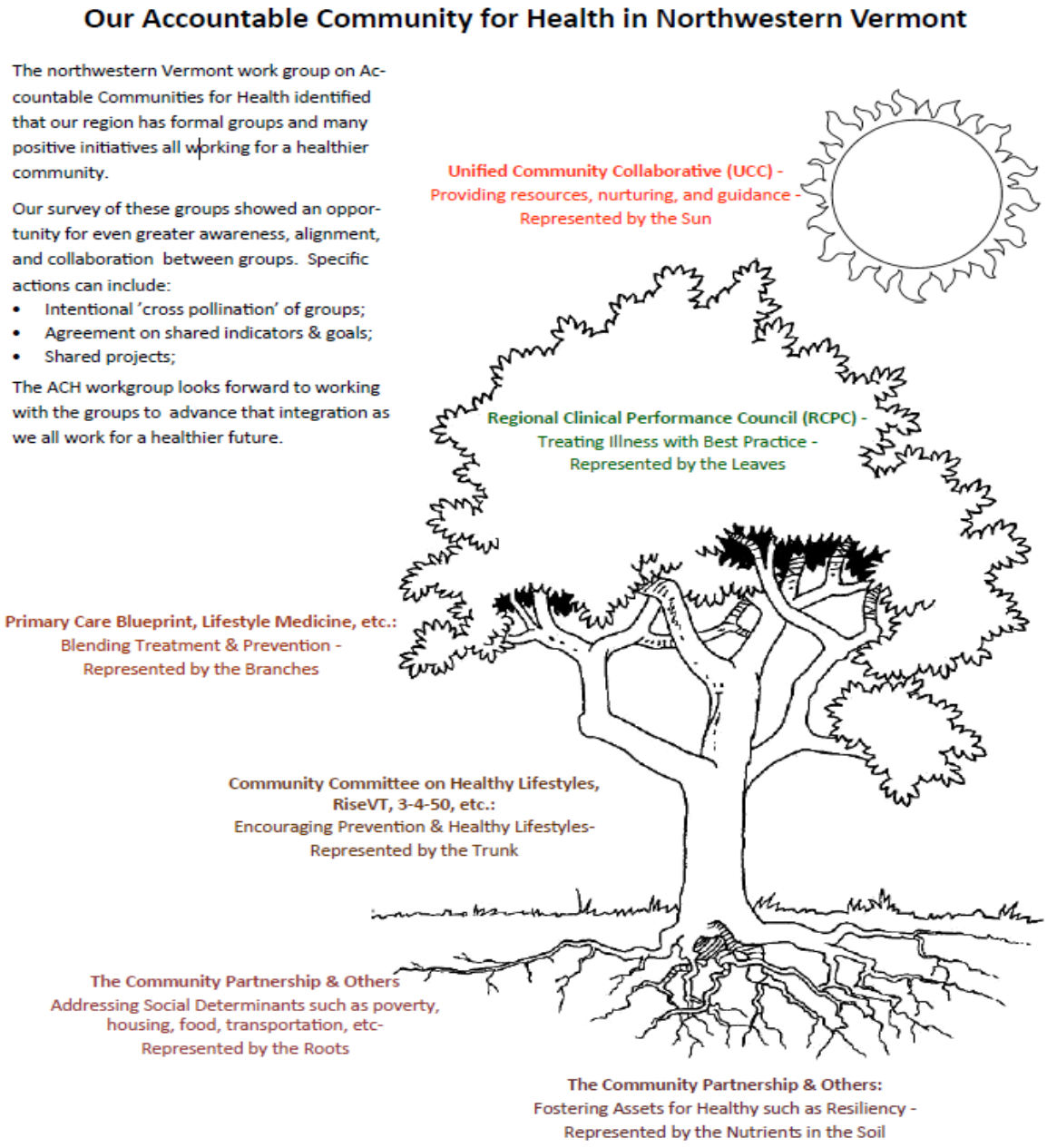


Figure 3: Presents 2018 non-adjusted rates, for the major categories of cost (as shown in Figure 1). Some services uniquely provided by Medicaid (e.g., case management, transportation) are reported separately as Special Medicaid Services (SMS). SMS expenditures in St. Albans are lower per capita than statewide.

ST. ALBANS HEALTH SERVICE AREA



2019 ACHIEVEMENTS

Fourteen Patient-Centered Medical Homes partnered with Franklin County Home Health, AgeWell and SASH to implement the OneCare VT Care Coordination Model, achieving 16% of high and very high risk attributed individuals "Care Coordinated." Teams developed the value proposition for using Care Navigator in anticipation of ACO members' access to their care plans. Partners are well-positioned to transition to the 2020 Care Coordination Model starting April 1.

In May, Quorum Health Resources conducted three days of stakeholder focus groups to assess care coordination across the spectrum in our community. We took 18 recommendations for improving structure, processes and measurement of coordinated care. Care coordination stakeholders identified transitions of care nodes, signals and information shared to streamline and standardize communication. The Northwestern Medical Center primary care practices, Cold Hollow Family Practice and Franklin County Home Health improved medication reconciliation processes. Medication reconciliation post-discharge is 95% for Medicare beneficiaries. Northwestern Pediatrics implemented screening for Food Insecurity with a warm hand off to the CHT for social determinants of health screening and support. In 2019, 5,676 families were screened, with 41 receiving CHT support.

Northern Tier Centers for Health (NOTCH) offered two day camps in Richford and Swanton to children aged 0-18 years with breakfast, lunch and activities during the summer months. In December, their clinics participated in the United Way Operation Happiness distributing holiday gift baskets for families. Northwestern Counseling and Support Services (NCSS) implemented Cognitive Behavioral Health for chronic pain in medical homes. The Regional Coordinator organized training for and held the first Youth WRAP program. St. Albans Primary Care provides group visits for individuals living with diabetes in collaboration with NMC Lifestyle Medicine Clinic.

St. Johnsbury Health Service Area

Program Manager: Laural Ruggles

St. Johnsbury By The Numbers

14,255	Primary care patients served at Blueprint practices in the past 2 years (based on insurance claims)
10.5	Community Health Team staff full time equivalents (FTEs)
2	Spoke staff FTEs
.8	Women's Health Initiative staff FTEs
14	Self-management workshops held
88	Self-management workshop graduates
8,943	Community Health Team encounters
106	Patients served in area Spokes (Medicaid only)

St. Johnsbury Community Health Team

St. Johnsbury Hospital Service Area Health Care Expenditures

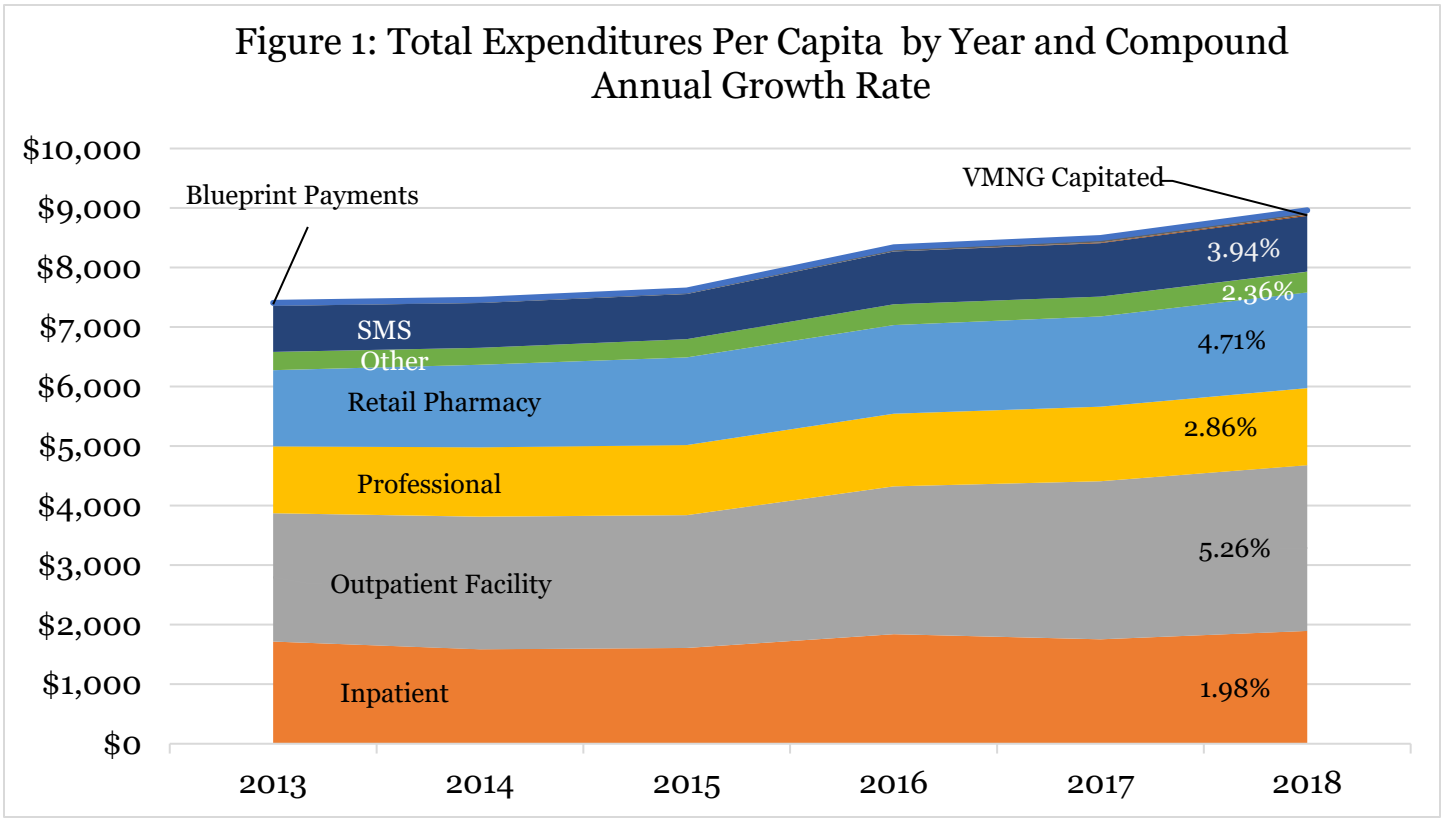


Figure 1: Presents unadjusted expenditures per capita by major category 2013-2018. The percentages on the right are the compounded annual growth across the time period. Every category showed increases, with outpatient and facility expenditures growing the most.

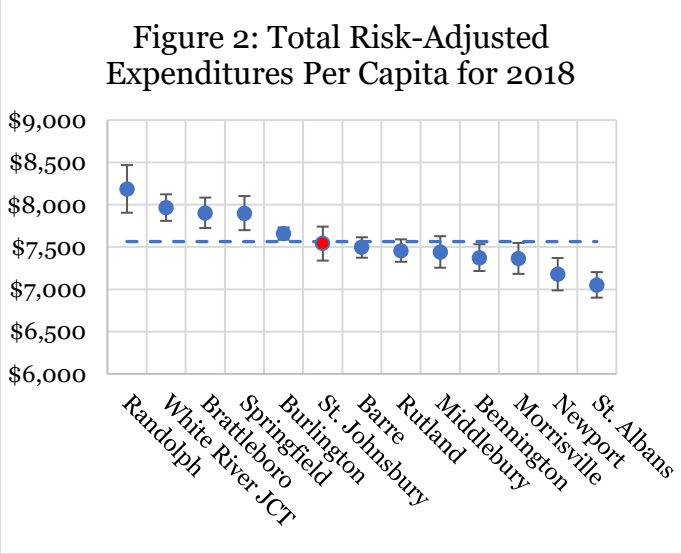


Figure 2: Presents annual risk-adjusted rates, including 95% confidence intervals. The blue dashed line indicates the statewide average. St. Johnsbury is at the statewide average.

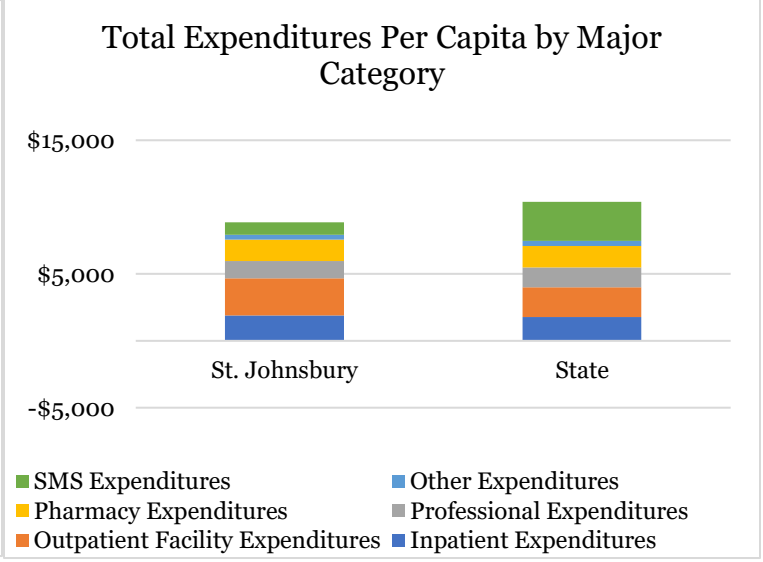


Figure 3: Presents 2018 non-adjusted rates, for the major categories of cost (as shown in Figure 1). Some services uniquely provided by Medicaid (e.g., case management, transportation) are reported separately as Special Medicaid Services (SMS). SMS expenditures in St. Johnsbury are lower per capita than statewide.

ST. JOHNSBURY HEALTH SERVICE AREA

Name of area Accountable Community for Health or Community Collaborative Group:

NEK PROSPER! CALEDONIA – SOUTHERN ESSEX ACCOUNTABLE HEALTH COMMUNITY

NEK Prosper! is committed to our shared goal of improving the health and well-being of the people in Caledonia and southern Essex Counties by integrating our efforts and services, with an emphasis on reducing poverty in our region.

We want everyone in our communities to be:

Well Nourished

Well Housed

Physically Healthy

Mentally Healthy

Financially Secure

2019 ACHIEVEMENTS

FIRST Home: Families In Recovery Staying Together (FIRST) Home is a strong community collaborative born from the Well Housed Collaborative Action Network (CAN) of the NEK Prosper Accountable Health Community. The CAN identified mothers in recovery as being a population with a gap in housing resources and one that is often considered "hard to house." FIRST Home creates a model where four mothers dealing with opioid addiction can focus on recovery while maintaining their family structure in a positive, healthy way.

Key elements of FIRST Home: community-based, centered on the individual, completely voluntary, provides professional and peer support services. While FIRST Home, a true community collaboration, will ensure that residents have access to a full spectrum of services and opportunities new mothers and their children need to succeed, it is first and foremost a home! All of the supports and services offered are secondary to ensuring that families in recovery have safe, affordable housing.

Partners who are committed to the success of the FIRST Home include: Northeast Kingdom Community Action (NEKCA); RuralEdge (housing), Kingdom Recovery Center, BAART, Northeastern Vermont Regional Hospital/Women's Wellness, Department of Children and Families/Family Services Division, Agency of Human Services/Field Services, SMART Team, Northeast Kingdom Human Services. Current funding for FIRST Home is an anonymous donation through Vermont Community Foundation (VCF) of $200,000; smaller grant from VCF of $25,000; Four Project Based vouchers awarded by the Vermont State Housing Authority to support housing costs valued at $25,200 annually. It is estimated that each dollar invested in FIRST home yields a savings return of $3.40.

ADDITIONAL FEATURED PROJECTS

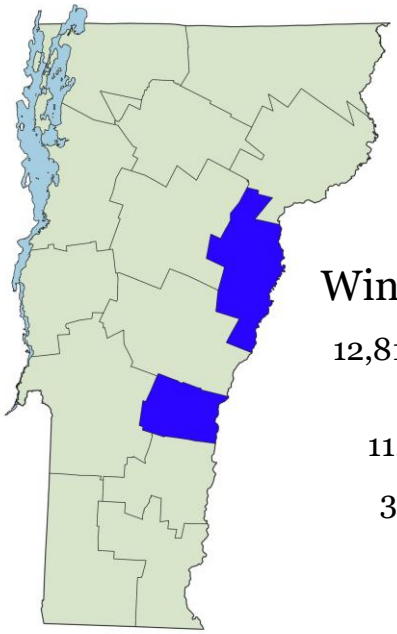
Improved Access to Primary Care: Corner Medical eliminated its new patient waiting list and established a new medical home for more than 250 patients. Cleaning up individual

provider and overall practice panels, adding capacity by bringing on a new Nurse Practitioner and establishing a Patient Care Access Group that met improve workflows and customer satisfaction which dramatically streamlined the new patient onboarding process allowed for them to eliminate their new patient waitlist in a few months.

Cervical Cancer Screening: NCHC completed and rolled out a new EHR template which enables clinical staff to easily process results for Paps performed in-house, set a next due date and record contact with the patient notifying her of the results. They completed an outreach and recall effort for patients due or overdue for cervical cancer screening. Currently, 77% of women age 23-64 have appropriate and timely cervical cancer screening, and 76% of eligible patients have a future Pap due date recorded.

Women's Health Initiative: Women's Wellness Center (WWC) created a workflow that briefly connected the Behavioral Health Specialist with each patient after screening. WWC created formal agreements with community partners for patient referral and care coordination. WWC staff also visited community partners to educate staff on the importance of asking the "One Key Question" and providing brief family planning counseling, and gave staff tools to educate patients on family planning options.

Screening, Brief Intervention, Navigation to Services (SBINS): NCHC has created a comprehensive SBINS form which incorporates One-Key Question, tobacco, alcohol and substance use screening; the PHQ-2 and question 9 regarding suicide; and questions about financial stress, transportation, interpersonal violence, food security and housing security from the CMS Accountable Health Communities screening tool. The form includes a section on patient intention which aligns with the Camden Cards domains. They hope to migrate from paper form to point of service screening on iPads.



Windsor Health Service Area

Program Manager: Jill Lord

Windsor By The Numbers

12,815	Primary care patients served at Blueprint practices in the past 2 years (based on insurance claims)
11.8	Community Health Team staff full time equivalents (FTEs)
3.5	Spoke staff FTEs
0	Women's Health Initiative staff FTEs
9	Self-management workshops held
56	Self-management workshop graduates
249	Patients served in area Spokes (Medicaid only)

Windsor Community Health Team

White River Junction Hospital Service Area Health Care Expenditures

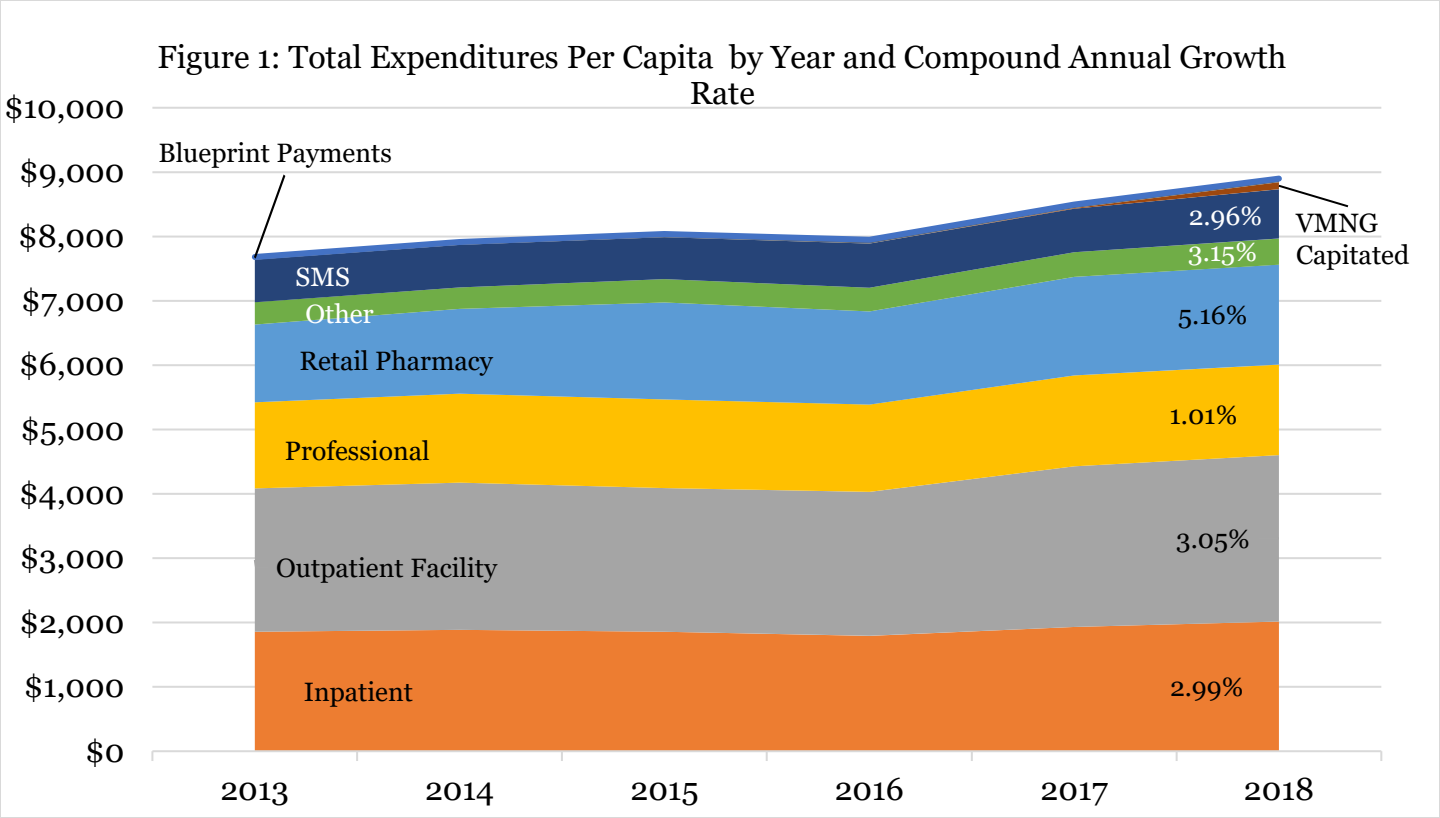


Figure 1: Presents unadjusted expenditures per capita by major category 2013-2018. The percentages on the right are the compounded annual growth across the time period. Every category showed increases, with Pharmacy expenditures showing the most growth.

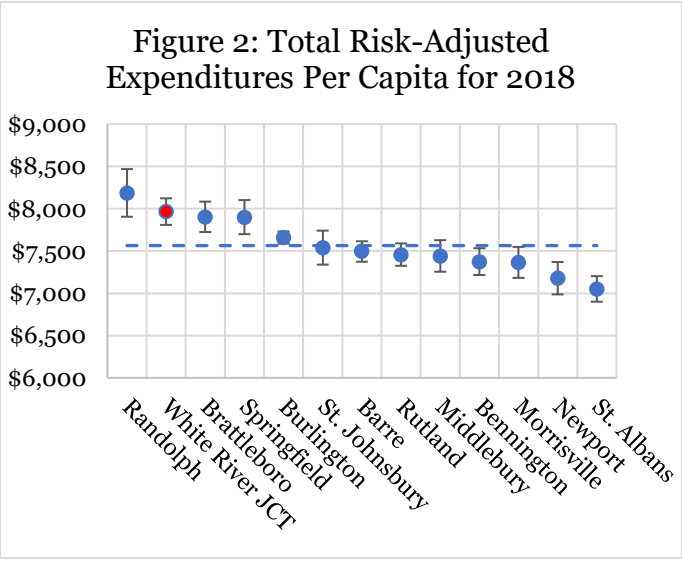


Figure 2: Presents annual risk-adjusted rates, including 95% confidence intervals. The blue dashed line indicates the statewide average. White River Junction is above the statewide average.

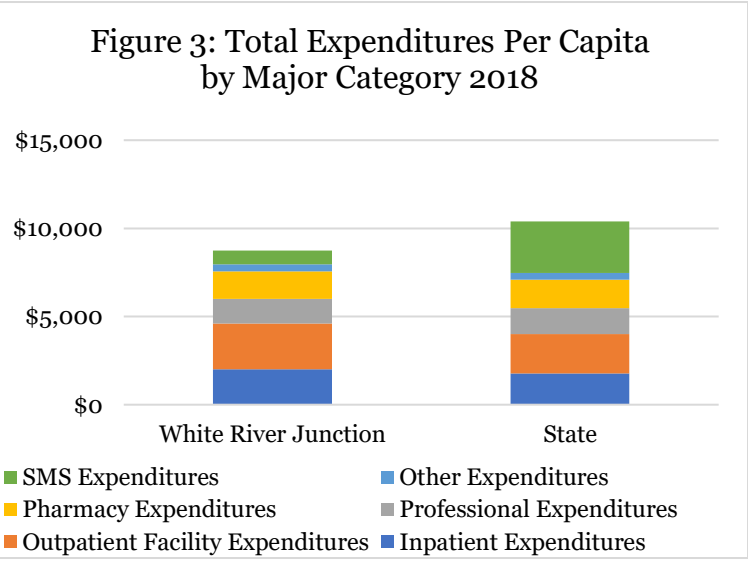


Figure 3: Presents 2018 non-adjusted rates, for the major categories of cost (as shown in Figure 1). Some services uniquely provided by Medicaid (e.g., case management, transportation) are reported separately as Special Medicaid Services (SMS). SMS and Outpatient Facility expenditures in White River Junction are lower per capita than statewide.

WINDSOR HEALTH SERVICE AREA

WINDSOR HEALTH SERVICE AREA COMMUNITY COLLABORATIVE AND THE UPPER VALLEY COMMUNITY COLLABORATIVE

Both Community Collaboratives bring together many engaged health and human service leaders and citizens who are committed to improve population health of our HSA.

The mission of Upper Valley Community Collaborative is to improve the quality of life of the people in the communities we serve. Quality improvement projects have included dental access for adults on Medicaid, behavioral health in schools/trauma-informed schools, care coordination workflows & referrals between agencies, food insecurity, Interagency Care Team meetings, and health & nutrition education.

The Windsor HSA Community Collaborative is an Accountable Community for Health. Our Mission is to increase the quality of healthcare, improve the patient care experience, contain costs, and to promote health equity. Quality Improvement activities includes improving blood pressure management, diabetes control, initiation and engagement and treatment for substance misuse, care coordination, nutrition, exercise and tobacco cessation, and Regional Falls Prevention. We also implemented a comprehensive Community Health Improvement Plan based on our Community Health Needs Assessment which was designed to have collective impact.

2019 ACHIEVEMENTS

Windsor Health Service Area through the leadership of Mt. Ascutney Hospital and Health Center has worked intentionally to create an Accountable Community for Health working with community partners and addressing eight major community health needs including access to mental health services, alcohol and drug misuse prevention, treatment and recovery, access to affordable health insurance, health care services and prescription drugs, family strengthening including poverty and childhood trauma, availability of primary care services, health care for seniors, affordable housing and availability of affordable adult dental care. In this effort we worked with 53 community partners. There was an investment from Mt. Ascutney Hospital and Health Center with of grant support for over 90 unique community health programs. (Our annual report is available per your request.)

White River Family Practice QI project for the past 6 months (which was completed 11/1/19) was chlamydia screening. Our baseline was well below the State average and our goal was to improve our rates by 20%. Our baseline for screening 16-24 year old females was 44%. At the end of this collaborative our rates improved to 71%. This was done by making this a “standard of care” and changing processes to make this improvement. Also, the practice staff provided patient education on vaping by displaying information on our bulletin boards in our exam rooms. This helped create a discussion between the provider and the patient and often by the parent to the provider (unaware of the outcomes of vaping). White River Family Practice also successfully completed NCQA re-certification!

A Goal of the UVUCC is to expand food access for all people within our community. Food access without stigma will help build a healthy community. The UVUCC is currently focusing on expanding food access for all people on our communities. The first step has

been to identify the current resources that are available and making that information readily available for anyone seeking it. A paper document has been created, a waterproof version is in development, and digital platform has been presented to Code for the Upper Valley for assistance is creating it.

ADDITIONAL FEATURED PROJECTS

This year Mt. Ascutney Hospital and Health Center faced a significant turnover of our Community Health Team and Collaborative Care Nursing staff. We invested significant time in training and rebuilding our team. We now have a strong, capable, hardworking and compassionate team to accomplish the work of care coordination. There was an intentional effort to build skills and capacity within our region working with community partners and OneCare Vermont. Se poem below that describes our team. Our Collaborative Care Nurses have built best practice approaches in chronic care management and education working with their provider colleagues.

We have worked intensively to reduce and prevent deaths and risk related to the Opioid epidemic. This work included Rapid Access to Medication Assisted Therapy (RAM) linking our Emergency Department to Connecticut Valley Recovery Services for timely ongoing treatment. Our ED became a naloxone distribution site. We also convened and led multisector work groups of community agencies and citizens working together to reduce barriers to substance use treatment in our community. Vermont Prescription Monitoring System reports that Windsor County has the lowest opioid prescribing rate in the state for the third year in a row. With the second lowest rate for prescription of stimulants and benzodiazepines.

In past years the UVUCC has sparked the implementation of adding a public health dental hygienist to Little Rivers Health Care, to improve adult access to oral care, which lead to a grant to sustain her. We established a digital resource guide for care coordinators from all organizations to share resource to better serve our clients. We created a group that supports schools in becoming trauma resilient. We work with schools to find out what resources they need for success.

To be of use

BY MARGE PIERCY

The people I love the best
jump into work head first
without dallying in the shallows
and swim off with sure strokes almost out of sight.
They seem to become natives of that element,
the black sleek heads of seals
bouncing like half-submerged balls.

I love people who harness themselves, an ox to a heavy cart,
who pull like water buffalo, with massive patience,
who strain in the mud and the muck to move things forward,

who do what has to be done, again and again.

I want to be with people who submerge
in the task, who go into the fields to harvest
and work in a row and pass the bags along,
who are not parlor generals and field deserters
but move in a common rhythm
when the food must come in or the fire be put out.

The work of the world is common as mud.
Botched, it smears the hands, crumbles to dust.
But the thing worth doing well done
Has a shape that satisfies, clean and evident.
Greek amphoras for wine or oil,
Hopi vases that held corn, are put in museums
but you know they were made to be used.
The pitcher cries for water to carry
and a person for work that is real.