Vermont

Advancing the Medical Home Model for Children and Youth
Created in Collaboration with the National Academy for State Health Policy

The National Center for Medical Home Implementation (NCMHI) and the National Academy for State Health Policy (NASHP) are collaborating on the development of state profiles designed to highlight public programs implementing and advancing the medical home model in pediatric populations. These updates are part of a formal partnership between NASHP and the NCMHI that focuses on exchanging information to improve medical home access for children and youth in medically underserved populations. If you have any questions about the information included in the updates, contact medical_home@aap.org.

The NCMHI is a cooperative agreement between the American Academy of Pediatrics and the Maternal and Child Health Bureau of the Health Resources and Services Administration.

Vermont has many programs in place to support healthy child development that have contributed to its recent recognition for having the healthiest kids in America. The bulk of Vermont's early health reform initiatives fall under the Blueprint for Health (Blueprint), a statewide multi-payer initiative established in 2006 to improve health outcomes, control costs, and deliver overall better care to Vermont citizens. Private partners in the initiative include the state chapters of the American Academy of Pediatrics and American Academy of Family Physicians and the Vermont Children's Health Insurance Program (CHIP). The Blueprint model incorporates multiple delivery system reforms to achieve its goals and has already experienced success in different areas.

PROGRAM COMPONENTS

Patient-Centered Medical Home (PCMH)

In 2007, the Vermont State Legislature directed the Blueprint for Health to launch a PCMH pilot that went statewide in December 2011. Medical homes in Vermont serve all residents, including both publicly and privately insured children. Per Vermont state legislation, medical homes are required to provide care coordination services to patients with chronic conditions, enable secure patient access to personal health information, and collaborate with community health teams to maximize the quality of care delivered to participating patients. Vermont requires that medical homes adhere to the National Committee for Quality Assurance (NCQA) recognition program standards.

As of the 2013 Blueprint Annual Report, there were 123 PCMH recognized PCMH practices, including approximately 20 pediatric practices, in Vermont serving 514,385 people in the state. Vermont has allocated many resources, including funding for electronic medical record expansion and practice coaching, to support practices transforming into medical homes. Clinicians serving children and families can receive support from the Vermont Child Health Improvement Program (VCHIP) at the University of Vermont, an initiative that works with pediatric practices to achieve NCQA recognition.

In addition to VCHIP, pediatric medical homes also receive support through Vermont's CHIPRA Demonstration Grant. One of the primary objectives for this grant work in Vermont is to extend the Blueprint medical home model to more pediatric practices by supporting NCQA PCMH assessments and practice facilitation for continuous quality improvement.

Community Health Teams (CHT)

Run in conjunction with medical homes, CHTs provide support to pri-mary care providers through coordinated community-based support services, population management, and quality improvement. CHTs are multi-disciplinary and locally based teams assembled to best meet the needs of the communities they serve. They can consist of nurse coordina-tors, social workers, nutrition specialists, community health workers, and public health workers. Types of services CHTs provide include care co-ordination, counseling, enhanced self-management, education, and coordi-nated linkages with targeted specialty services, including specialty care, mental health & substance use treatment, social services, and economic services. All payers share responsibility for funding each CHT.

Per state legislation, medical homes are required to collaborate with CHTs and must develop and implement a comprehensive plan for participating patients. Several CHTs have incorporated pediatric specific resources. For example, the CHT serving Rutland, Vermont now includes a pediatric social worker to collaborate with families, primary care and behavioral health providers, schools, agencies, and specialists to improve health outcomes for children.

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PROGRAM COMPONENTS (CONTINUED)

Health Information Technology (HIT)
Vermont's statewide HIT infrastructure is crucial to the success of Blueprint programs and supports efforts related to health information exchange, population management, evaluation, and guideline-based care. The non-profit organization Vermont Information Technology Leaders runs the Vermont Health Information Exchange (VHIE), a nationally recognized Health Information Exchange that connects electronic health record systems via three interfaces: admit, discharge and transfer orders; continuity of care documents; and medical document management reports.

PAYMENT MODEL

PCMH recognized practices receive enhanced per patient per month (PPPM) payments in addition to fee-for-service reimbursement. PPPM payments vary based on level of NCQA-PCMH recognition; in 2012 insurers made payments averaging $2.00 PPPM (including both adult and pediatric populations). This payment structure promotes increased access to care, improved communication, enhanced preventive health services, better-coordinated care, and population management. In addition to PCMH payments, all insurers contribute to the costs for CHTs. The current rate to support CHTs is $70,000 (about 1 FTE) for every 4,000 patients (including both adult and pediatric populations).

OUTCOMES

In January 2014, Vermont released the 2013 Vermont Blueprint for Health Annual Report which included findings that suggest programs implemented under the Blueprint have had numerous positive effects. For example, Blueprint participants were found to experience better clinical quality on measures such as well-child visits and adolescent well-care visits among others. The report indicates improved utilization measures such as higher rates of primary care visits and lower rates of all-case inpatient hospitalizations. Finally, the report also shows annual cost savings that amount to $386 per commercially insured child and $200 per pediatric Medicaid enrollee.

FAST FACTS:

80,499: Children enrolled in Medicaid and CHIP in Vermont in FY 2012 (72,929 Medicaid; 7,570 CHIP)

96.7% : The participation rate for those eligible for the Vermont CHIP program

87.2%: The national participation rate for those eligible for the CHIP program

For more information on state public health initiatives related to pediatric medical home, visit www.medicalhomeinfo.org.