Vermont is helping to change the face of primary care with a new model that makes a medical practice the home for all a patient’s needs. Clinicians and researchers from the College of Medicine are playing integral roles in these efforts.

It was a cold day in January when Rita Pinard’s doctor told her what she didn’t want to hear. “You have diabetes,” Pinard recalls her saying. “If your numbers don’t go down in three months, we’ll need to start you on medication.” Pinard, 57, of St. Johnsbury, was close to tears at the news. She had been told she was pre-diabetic in the past, but somehow that fact had never really sunk in. Fortunately for Pinard, her diagnosis coincided with a transformation in the way care is delivered in her community. Her physician’s practice was recently recognized as a patient-centered medical home — a model of care designed to provide seamless coordination of services.
A meeting of the St. Johnsbury Community Care Team.

Whatever they’re coming in for, we have two agendas: what they came in for and then there’s always our agenda, which is ‘OK, are you caught up on everything?’

— Dana Kraus, M.D.
St. Johnsbury Family Health Center

As the health care reform debate rages on Capitol Hill, the face of primary care is changing in the hills of Vermont, with physicians’ practices adopting a model of care known as medical homes. The effort is part of a larger health reform initiative called the Vermont Blueprint for Health — a public-private partnership seeking to improve health and the health care system in the state. The goal is to help people with chronic conditions and those at risk for chronic conditions manage their own health — and reduce the soaring health care costs associated with chronic illness.

Clinicians and researchers at the University of Vermont College of Medicine play an integral role in these efforts, helping physicians’ practices secure medical home recognition from the National Committee on Quality Assurance and, most importantly, evaluating the success and effectiveness of Blueprint programs. Faculty members and staff have helped plan and guide the Blueprint, fueled in part by a desire to improve the quality of care and make primary care careers more attractive in the wake of a looming workforce shortage.

All of this work is drawing national attention, as officials from other states seek to learn from Vermont’s experience. U.S. Representative Peter Welch, D-Vt., recently incorporated ideas and solutions from the Blueprint into national health care reform legislation, including language promoting medical homes.

“Vermont is one of the states at the forefront of thinking about how to make this happen on the ground,” said Enrique Martinez Vidal, vice president of AcademyHealth and director of the Robert Wood Johnson Foundation’s State Coverage Initiatives project. Martinez Vidal recently brought teams from five states to Vermont to learn about the Blueprint and observe medical homes in action.

The security of home
Throughout the country, physicians’ practices are increasingly turning to the medical home model as they look to reform their health care systems. To become a patient-centered medical home, a practice must meet standards set by the National Committee on Quality Assurance. They are measured on nine aspects of care, including issues such as appointment access, communication, patient tracking and registry functions, patient self-management support, electronic prescribing and performance reporting and improvement.

Becoming a medical home not only helps improve the quality of care — it also increases payment to the physician’s practice. Once they achieve patient-centered medical home status, selected practices in three Blueprint Integrated Pilot communities receive an enhanced provider payment to offset their increased costs. These funds are distributed on a per-patient per-month basis through a multi-insurer partnership composed of the major private insurance companies operating in Vermont and the Vermont Medicaid program. The Federal Medicare is not yet a member. Practices that become patient-centered medical homes make use of additional staff, including behavioral health specialists and chronic care coordinators — usually a registered nurse who works closely with patients to coordinate their care among self-management, community programs, primary care, and specialty care.

Being a medical home means applying preventative care to the whole population of patients, not just those with chronic problems, says Dana Kraus, M.D., a family practitioner who works at St. Johnsbury Family Health Center, one of seven patient-centered medical homes in Vermont. “It’s putting in place reminder systems to capture patients so that we’re making sure that they get everything.” For example, if a patient comes in with a stubbed toe, the doctor might also check to make sure they have had a regular pap smear or mammogram — or that they are caught up on their tetanus shot.

“Whatever they’re coming in for, we have two agendas: what they came in for and then there’s always our agenda, which is ‘OK, are you caught up on everything?’” Kraus says.

What is a Medical Home?
In 2008, the National Committee for Quality Assurance, a non-profit organization dedicated to improving health care quality, released standards for developing patient-centered medical homes. These standards are based on principles developed by the American College of Physicians, the American Academy of Family Physicians, the American Academy of Pediatrics, the American Osteopathic Association and others.

A patient-centered medical home is a model of care based on strengthening the doctor-patient relationship and providing seamless coordination of care — with a strong emphasis on preventative medicine. The patient is encouraged to become an active partner in his or her care, and work towards self-management of his or her illness.

Patient-centered medical homes use health registries, advanced information technology and health information exchange to ensure that patients receive the indicated care when and where they need it. Practices that achieve patient-centered medical home recognition may receive enhanced provider payments. To be recognized as medical homes, practices must meet nine standards which include:

- Access and Communication
- Patient tracking and registry functions
- Care management
- Patient self-management support
- Electronic prescribing
- Test tracking
- Referrals tracking
- Performance reporting and improvement
- Advanced electronic communications

Each standard has multiple elements; practices are scored depending on how well they comply with these elements. For more information about medical homes, visit: www.ncqa.org and www.pcpcc.net
Shauna Brittell is a chronic care community health worker who is part of the Community Care Team shown on page 30. Part of her role under the medical home effort is to educate patients and their families to make better choices in circumstances that will affect their health. On one July afternoon she accompanied Christina, mother of a small child and wife of a person who has asthma and is at a risk for diabetes, through the family’s weekly shopping at the supermarket in Lyndonville. She is responsible for analyzing whether or not physicians’ practices are complying with the standards to become patient-centered medical homes. She also helps Vermont practices apply for recognition as medical homes with the National Committee on Quality Assurance. Krulewitz travels to physician practices across the state, reviewing medical records and asking questions: Are patients able to identify patients with diabetes who are overdue for testing, or patients who are due for a colonoscopy. Those patients are then typically contacted by mail.

“When you send out that first letter that says we really care about you, we believe that prevention is the key to having a long and happy life, they enjoy that,” says Clinical Assistant Professor of Medicine Jennifer Gilwee, M.D.’97, medical director of the practice. The key is preventing illness down the road, Gilwee says. “What I do now may prevent a heart attack in 10 to 15 years.”

A natural partner

As physicians and patients begin to experience new ways of delivering care, researchers at the Vermont Child Health Improvement Program (VCHIP) at the College of Medicine are conducting thorough evaluations to determine if the changes are working.

Julie Krulewitz, Ph.D., a researcher with VCHIP, works on evaluating patient-centered medical homes in Vermont, as well as evaluating other Blueprint projects. She is responsible for analyzing whether or not physicians’ practices are complying with the standards to become patient-centered medical homes. She also helps Vermont practices apply for recognition as medical homes with the National Committee on Quality Assurance. Krulewitz travels to physician practices across the state, reviewing medical records and asking questions: Are patients able to see their assigned primary care provider? Does the practice have a 24-hour service to answer questions? Do patients have a primary care provider? Data Krulewitz gathers directly inform the work of the Blueprint in developing new strategies for improvements and assessing the effectiveness of current efforts.

Because of its research and evaluative expertise, UVM brings an important set of skills to the table, says Judith Shaw, Ed.D., R.N., M.P.H., executive director of VCHIP and one of the early planners of the Blueprint for Health. “We’re playing the role of evaluator. That sort of completes the picture,” Shaw says.

UVM is a natural partner in health care reform in other ways as well, particularly as it pertains to the health care workforce. As a leader in primary care education — UVM was recently ranked sixth in the nation for primary care education by U.S. News & World Report — the university has a vested interest in finding a model for primary care practice that is satisfying for people and attractive to graduating students, says Charles MacLean, M.D., interim associate dean for primary care, who serves on the Blueprint’s Executive Committee and on a Primary Care Workgroup that advises the Blueprint.

“There’s a lot of attention being paid to primary care right now, particularly as regards the patient-centered medical home, and part of it is coming out of a sense of a looming crisis in workforce,” MacLean notes.

Wrapping care around the patient

Vermont’s health reform efforts are already helping to make primary physicians’ jobs more satisfying, say those involved with the Blueprint.

One of the unique aspects of the Blueprint Integrated Pilots is the creation of Community Care Teams — groups of health professionals that offer a wide range of services not typically provided in the doctor’s office. Services can include diet and nutrition counseling, tobacco cessation, mental health services, social service referrals, payment assistance, home visits and others. Primary care physicians can refer patients to these teams.

Through the Blueprint, pilot communities, with financial assistance from the insurance companies and the state, are creating these teams up front as a part of the infrastructure of delivering primary care — something no other state is currently doing, says Lisa Dubsky Watkins, M.D., assistant director of the Blueprint at the Vermont Department of Health. To date, two Community Care Teams have been formed in the state — one in Chittenden County and one in St. Johnsbury — with a third one planned for Central Vermont.

The team makes a huge difference in how primary care physicians practice medicine, says Pam Smart, who coordinates the St. Johnsbury Community Care Team. “The whole purpose is to lighten the load of the primary care physician and train him to think at a population level.”

Clinical Assistant Professor Jennifer Gilwee, M.D.’97, feels being a part of a medical home allows her to practice better preventive medicine.
The Vermont Blueprint for Health

The state of Vermont launched the Blueprint for Health in 2003 with the initial goal of focusing on obesity-related disease. The blueprint is a statewide plan designed to reduce the health and economic impact of the most common chronic conditions and focus on their prevention.

In 2006, the Blueprint was given further focus and written into law as the state’s plan for changing health care delivery. Further legislation in 2007 directed the Blueprint to work on establishing medical homes. In 2008, the state launched the Blueprint Integrated Pilot Program and selected communities to participate based on a competitive process. Participating practices were given the infrastructure and financial incentives to operate a patient-centered medical home. Major components of the pilot program include financial reform, the creation of Community Care Teams, community activation and prevention, the use of health information technology and multi-dimensional evaluation.

Currently, there are two pilot projects operating in the state — in Chittenden County and St. Johnsbury. A third pilot is planned for Central Vermont. The following practices are currently participating and have been recognized as patient-centered medical homes:

### Chittenden County
- Aesculapius Medical Center, a practice of Fletcher Allen Health Care, South Burlington (15,774 patients)
- Eugene Moore, M.D., private practice, Burlington (1,800 patients)

### St. Johnsbury
- Caledonia Internal Medicine, a practice of Northern Counties Health Care, St. Johnsbury (2,011 patients)
- Concord Health Center, a practice of Northern Counties Health Care, Concord (2,183 patients)
- Corner Medical, a practice of Northeastern Regional Vermont Hospital, Lyndonville (14,500 patients)
- Danville Health Center, a practice of Northern Counties Health Care, Danville (3,088 patients)
- St. Johnsbury Family Health Center, a practice of Northern Counties Health Care, St. Johnsbury (2,822 patients)

Source: Vermont Blueprint for Health’s 2008 Annual Report. More information can be found at: http://healthvermont.gov/