ARTICLE

Successful Integration of Pediatrics Into State Health Care Reform Efforts

Judith S. Shaw, EdD, MPH, RN, FAAP, Susan E. Varni, PhD, Elizabeth Cheng Tolmie, EdD, MSW, Mary Kate Mohlman, PhD, MS, & Valerie S. Harder, PhD, MHS

ABSTRACT

Health care reform in Vermont promotes patient-centered medical homes (PCMH) and multi-disciplinary community health teams to support population health. This qualitative study describes the expansion of Vermont's health care reform efforts, initially focused on adult primary care, to pediatrics through interviews with project managers and facilitators, CHT members, pediatric practitioners and care coordinators, and community-based providers. Analyses used grounded theory, identifying themes confirmed by repeat occurrence across respondents. Respondents believed that PCMH recognition and financial and community supports would improve care for pediatric patients and families. Respondents shared three main challenges with health care reform efforts: achieving PCMH recognition, adapting community health teams for pediatric patients and families, and defining roles for care coordinators. For health care reform efforts to support pediatric patients and be family-centered, states may need additional resources to understand how pediatric and adult primary care differ and how best to support pediatrics during health care reform efforts. J Pediatr Health Care. (2017) ■, ■-■.

KEY WORDS

Patient-centered medical home, family-centered care, community health team, care coordination

Judith S. Shaw, Professor of Pediatrics and Nursing, University of Vermont, Burlington, VT.

Susan E. Varni, Research Specialist, University of Vermont, Burlington, VT.

Elizabeth Cheng Tolmie, Consultant, Beth Tolmie Consulting, South Burlington, VT.

Mary Kate Mohlman, Director of Health Care Reform, State of Vermont, Waterbury, VT.

Valerie S. Harder, Associate Professor of Pediatrics and Psychiatry, University of Vermont, Burlington, VT.

Conflicts of interest: None to report.

This work was supported by the Children's Health Insurance Program Reauthorization Act (CHIPRA) [1Z0CMS030541]. The funding source had no involvement in study design, collection, analysis and interpretation of data, writing of the article, or decision to submit the article for publication.

Correspondence: Valerie S. Harder, PhD, MHS, Vermont Child Health Improvement Program (VCHIP), Department of Pediatrics, University of Vermont, St. Joseph's 7, UHC Campus, 1 South Prospect St., Burlington, VT 05401; e-mail: valerie.harder@med.uvm.edu.

0891-5245/$36.00

Copyright © 2017 Published by Elsevier Inc. on behalf of the National Association of Pediatric Nurse Practitioners.

http://dx.doi.org/10.1016/j.pedhc.2017.07.008

INTRODUCTION

A challenge in health care reform is meeting the varying needs of populations within a community from pediatrics to geriatrics. Beginning in 1992, a series of legislative actions in Vermont built on the foundational idea that all residents should have "access to quality health services at costs which are affordable" (Hall, 2000; Leichter, 1993; Act 128, 2010). Part of Vermont's health care reform included the creation of the Vermont Blueprint for Health. The program began in 2003 with a strong focus on adult chronic conditions, more recently shifting to strengthening primary care for the broader population. In 2011, several legislative acts supported the Blueprint program's expansion to all Vermont primary care practices (Act 128, 2010; Act 191, 2006), including pediatrics. Today, all 153 pediatric-serving primary care practices in Vermont are eligible for services from the Blueprint, and at the time of this writing, 109 (71%) participate in the Blueprint and are receiving

services. The Blueprint's goal is to reduce annual medical expenditures and use rates of Vermonters; initial results show that the goal is being met, with significant reductions in both measures (Jones et al., 2015).

The Blueprint model consists of three primary components that aim to reduce health care costs and improve population health (Health, 2010; Wilson, 2008). The first is the patient-centered medical home (PCMH; American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, & American Osteopathic Association, 2007; American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, & American Osteopathic Association, 2011). The medical home builds on the chronic care model (Gabbay, Bailit, Mauger, Wagner, & Siminerio, 2011), supports the integration of health systems and services for patients, and promotes health maintenance and well-being (Hoff, Weller, & DePuccio, 2012; Jackson et al., 2013). These services are provided with assistance from community health teams (CHTs), the second of the Blueprint's components. CHTs locate multidisciplinary professionals in each of Vermont's 13 health service areas. They are coordinated by Blueprint project managers to provide support services such as nutritional guidance, healthier living workshops, social work, and care coordination (Department of Vermont Health Access, 2015; Losby et al., 2015). The final Blueprint component involves adoption of health information technology that enables practices to better serve their patients (Health, 2010). The Blueprint model creates medical neighborhoods that place the PCMH within a network of community health care professionals and resources that together support and coordinate health care (Fisher, 2008).

For example, as part of the PCMH recognition process, a practice may decide to focus on improving rates of adolescent well-care visits. During a well-care visit, possible depression and food insecurity are identified, leading to the adolescent beginning treatment for depression and being referred to a CHT social worker, who can connect the adolescent with community-based resources based on the adolescent's needs. After referrals and appointments are made, the use of health information technology allows for the adolescent's medical summary data (such as continuity of care documents) to be shared among medical providers. The shared medical summary data may allow a specialist treating the adolescent for other medical issues to learn that a depression diagnosis has been added to the child's primary care medical summary.

Additionally, through capitated payments, the Blueprint offers financial and infrastructure support for primary care practices as they transition to PCMHs and begin their work with the CHT to provide coordinated and comprehensive care (American Academy of Family Physicians et al., 2007; Ewing, 2013; Thompson et al., 2015). One such support is the availability of facilitators who help practices achieve medical home recognition, designing quality improvement efforts and implementing health information technology (Agency for Healthcare Research and Quality, 2013b; Bielaszka-DuVernay, 2011; Health, 2010). Specifically, practice facilitators help practices achieve PCMH recognition from the National Center for Quality Assurance (NCQA).

Although initially focused on the adult population, the Blueprint statewide expansion gave pediatric practices the opportunity to participate in becoming PCMHs, accessing CHT resources, and adopting health information technology. However, little was known about how these three program components would translate to a pediatric setting. Before expansion, CHTs focused on the needs of practices already enrolled in the Blueprint, most of which predominantly served adult patients. Therefore, they concentrated their efforts on health issues prevalent among adults. Similarly, pediatric practices perceived the 2008 NCQA PCMH standards as emphasizing conditions and practice processes more typical of adult rather than pediatric patient care. Consistent with the 2015 National Association of Pediatric Nurse Practitioners position statement, Vermont aimed to build upon the vision that "all children and their families will have access to comprehensive, high-quality health services within a pediatric health care/medical home from qualified pediatric health care providers" (National Association of Pediatric Nurse Practitioners, 2016).

In 2010, the Vermont Child Health Improvement Program acquired funding that enabled hiring pediatric-informed facilitators to work exclusively with pediatric practices as they sought medical home recognition. The supposition was that practice facilitators with experience in pediatric environments could guide practices through the PCMH recognition process by framing the requirements for recognition in ways relevant and appropriate for pediatric practices. Similarly, CHTs, flexible by design, could adjust to meet the needs of a pediatric population. This article describes the addition of pediatric practices into the Blueprint, with a focus on the suggested adaptations needed to best serve pediatric patients and their families.

METHODS

Overview

This qualitative study captures perspectives gathered through interviews conducted in 3 of 13 regionally based Blueprint health service areas in Vermont between March and November of 2013. The three health service areas were chosen to represent a cross-section of operating pediatric practices in Vermont. They include rural and urban areas and large and small pediatric and family medicine practices, and they contain

Download English Version:

https://daneshyari.com/en/article/8573552

Download Persian Version:

https://daneshyari.com/article/8573552

Daneshyari.com