Goal: To create a seamless integrated continuum of health services for all children and their families (prenatal to 22 years old) that includes efforts directed at health promotion, prevention and early intervention to intensive treatment and long term supports. The integrated system is designed to provide services and supports to the family unit, not just the child ultimately increasing the care experience and using resources effectively.

Hypothesis: Providing health promotion, prevention and early intervention including education and skill development will produce more favorable outcomes at a lower cost than the current practice of waiting until circumstances are bad enough. This will be better care for children and families and allow for more effective use of the resources.

Regulatory Framework: Federal Medicaid EPSDT mandate requires coordination with all services (Maternal and Child Health; Title V; Title IV-E and IDEA part B and part C as well as other social programs). Global Commitment provides for one regulatory and managed care framework across all children's programs and more readily aligns with holistic care required by EPSDT and Vermont's healthcare reforms efforts lead us to population based services, positive experience of care and reduced per capita costs.

Content Areas: prenatal, early childhood development, mental health and social emotional health, developmental needs and disabilities, substance use and abuse, special health care needs, strengthening families and parent skill development*, integration and working partnerships with all health care providers.

System Change Efforts Include

- Family systems, strength based & informed decision making by families
- Intervene earlier and community based
- Functional needs considered not just diagnosis
- Common and consistent intake, screening, and assessments with multi-disciplinary teams and one plan of care
- Unified AHS guidelines, criteria & common documentation
- Identified lead care coordinator
- Integrate funding with unified & simplified reimbursement & oversight – payment reform drives service delivery reform
- Outcome based contracts
- Modern IT structures to share information & reduce redundancies
- AHS contracts with the provider network will be combined and duplication eliminated

Targeted Funds

- All AHS funds that provide some level of treatment, support or intervention in the identified content areas; for further discussion is the inclusion of all child healthcare dollars
- Inventory of the funding in the content areas is approximately $145M (does not include medical services)
- Purposefully redistribute treatment and intervention funding towards health promotion, prevention and early intervention as payment reform creates opportunities for service delivery reform on the high end

The Pilot Region

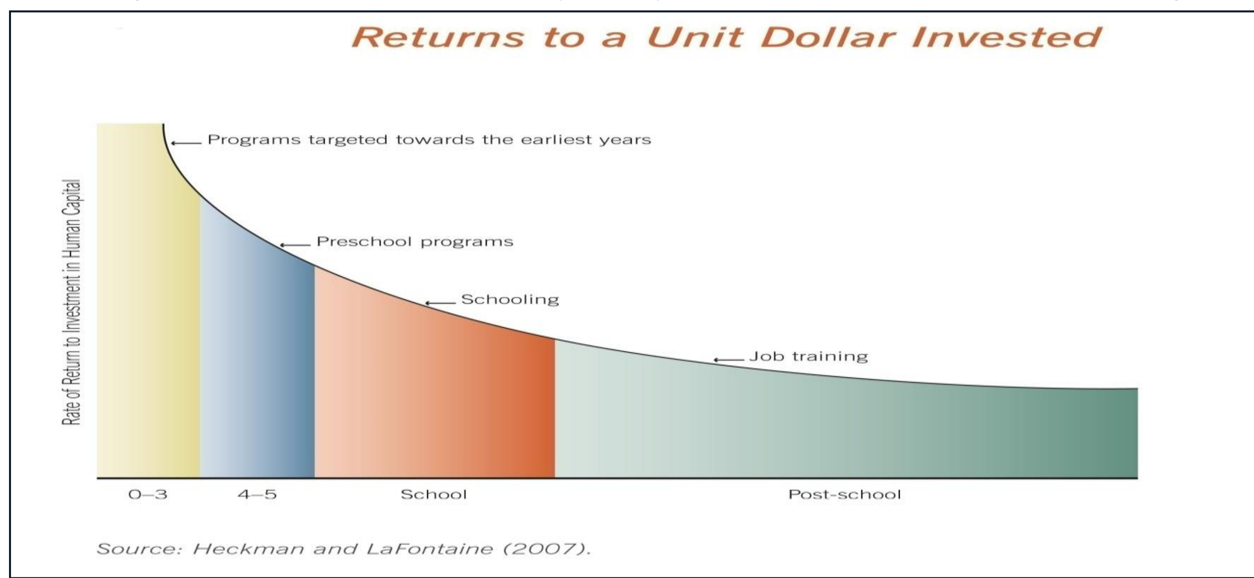
- Streamlined documentation
- Created a Per Member Per Month payment
- Created flexibility that didn't previously exist
- Allowed more prevention services, short-term interventions and more creative community based intensive services

- Focus is now on outcomes and quality of services instead of how many services were provided
- Created formal Local Agreements that include: local governance and decision making, roles and responsibilities of providers, service priorities including prevention and early intervention, clinical triage and utilization management, treatment/family support planning and outcome tracking for the children and families in their given region.
- AHS Agreements now have unified and simplified grant requirements including service definitions, reporting, outcomes tracking and quality oversight expectations. Additionally there is an aggregate annual cap, service flexibility, no prior authorizations or service limits which created more flexibility to serve the regional population in a preventive manner, provide consultation and easier access to health promotion and/or short-term interventions.

Financial Model

- Global Budget/Aggregate Annual Cap: The local budget and subsequent provider contract is based on current state obligations and historical caseload
- Caseload Targets and Incentives: Annual Caseload targets are established using historic averages
- Incentive Payments: Based on utilization and expenditures (adjusted for rate increases) of intensive services that are prior authorized and paid centrally by the State and historically not under the direct control of any one local provider (may need to change due to ACO model). Savings must be used for local programs that support protective factors in Strengthening Families.

Healing is Economic! Where Science, Policy and Experience Meet. The Economist are Listening



Many of our social problems, such as crime, are traced to an absence of the social and emotional skills, such as perseverance and self-control, that can be fostered by early learning. Crime costs taxpayers an estimated $1 trillion per year.

-James Heckman, Nobel Prize Winning Economist, *University of Chicago*

**Dr. Felitti –Author: Adverse Childhood Experiences stated the number one public health issue is parenting skill development*