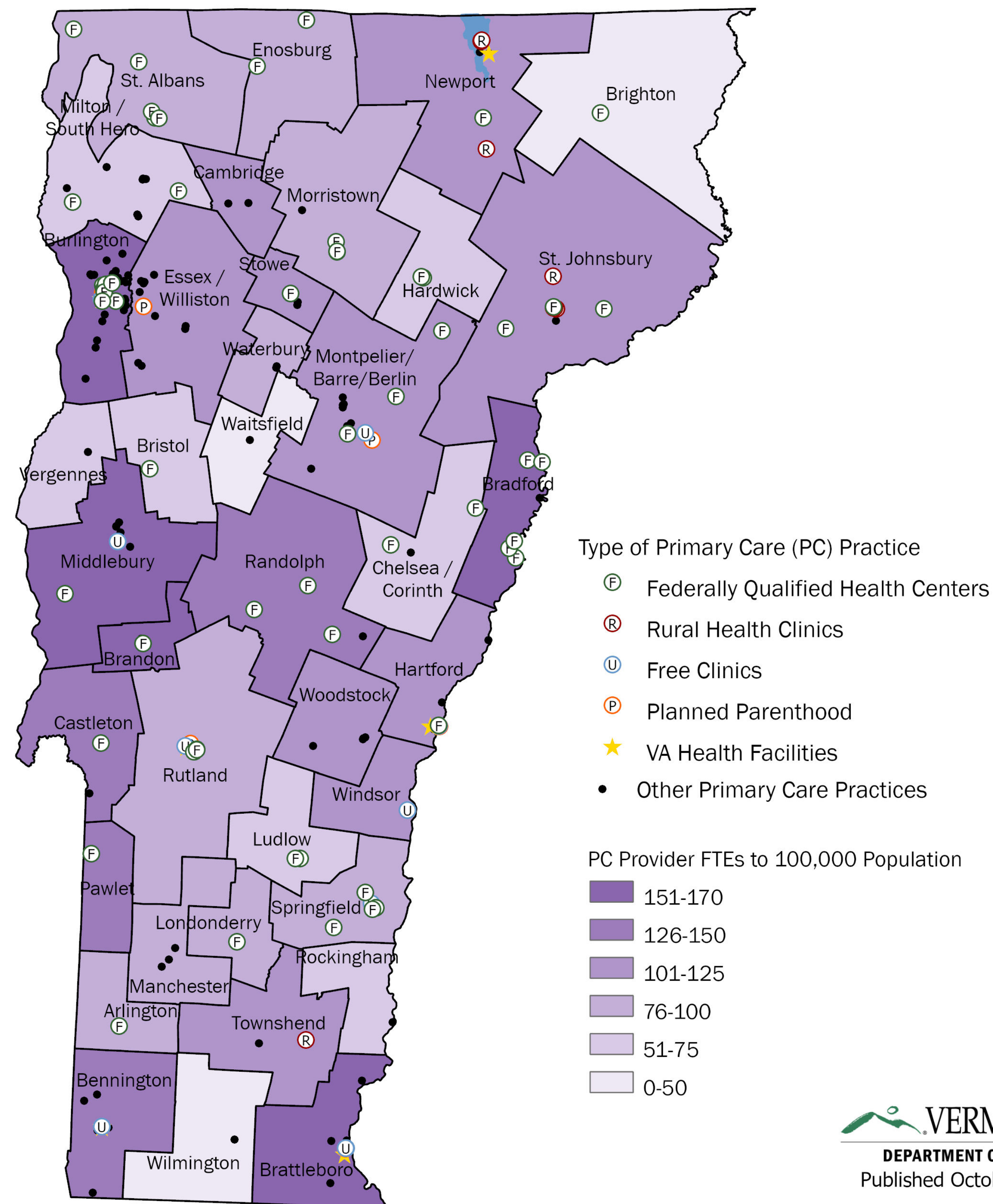
Overview of Primary Care in Vermont

March 31, 2026

Jessa Barnard, VMS Executive Director, jbarnard@vtmd.org

PRIMARY CARE PRACTICES – ALL



215 Total

Icons for:
- FQHCs (49)
- RHCs (10) (*note, 9 owned by hospitals)*
- Free & Referral Clinics (10)
- Veterans Affairs clinics (6)

Dots for:
- Practices owned by hospitals (50)
- Multi-site independent practices (30)
- Independent practices (69)

- Source: Vermont Department of Health Office of Rural Health and Primary Care, https://www.healthvermont.gov/systems/health-professionals/dental-and-primary-care

PRIMARY CARE PRACTICES – BLUEPRINT PATIENT CENTERED MEDICAL HOMES

Total primary care practices participating in the Blueprint for Health Patient-Centered Medical Home Program: 124

- Hospital Owned: 38
- Independent: 40
- FQHC: 46

Source: https://blueprintforhealth.vermont.gov/patient-centered-medical-homes, as of Feb 2026

Practices supported by the Blueprint to achieve patient Centered Medical Homes under the National Committee for Quality Assurance (NCQA) standards covering practice structure, patient care management, patient access, care coordination, performance measurement

Vermont insurers (Medicaid, Medicare, major commercial insurers, and some self-insured businesses) support practice transformation by providing a base per-member per-month (PMPM) payment to each Blueprint Medical Home

REPORT TO THE VERMONT LEGISLATURE

Agency of Human Services

280 State Drive
Waterbury, VT
www.humanservices.vermont.gov

[phone] 802-241-0440
[fax] 802-241-0450

Annual Report on Blueprint for Health

In accordance with Act 18 V.S.A. § 709

Submitted to: House Committee on Health Care
Senate Committee on Health and Welfare
Health Care Oversight Committee

Submitted by: Jenney Samuelson
Secretary, Agency of Human Services

Prepared by: Dr. John M. Saroyan
Executive Director, Blueprint for Health

Report Date: January 26, 2026

The Agency of Human Services strives to improve the health and well-being of Vermonters today and tomorrow and to protect those among us who are unable to protect themselves.

Statewide Measures for CY2023			
Patients	Total VHCURES (Excluding Self-Insured) Members	Blueprint PCMH Primary Care Attributed Members	Other Primary Care Attributed Members
Total Expenditures Per-Member-Per-Year*	$8,491.01 ± $44.37	$8,126.80 ± $58.60	$9,325.20 ± $90.21
% members with Primary Care Visit in Year	92.2% ± 0.2%	92.4% ± 0.4%	90.3% ± 0.5%

Note: The total expenditures given in Table V.A.2 are risk-adjusted values, not raw values (actual dollars spent). Since these values are risk adjusted, they do not reflect an exact dollar amount of savings for Blueprint attributed patients, but provide evidence that the relative costs are less for Blueprint attributed patients.

Source:
https://blueprintforhealth.vermont.gov/sites/bfh/files/documents/2025_Blueprint_For_Health_Annual_Report_0.pdf

PRIMARY CARE PRACTITIONERS

2022 Physician Census

Statistical Report

569 physicians (22% of total or **406.3 FTE**) provide mainly primary care including:

- 275 Family Practice
- 131 Internal Medicine
- 64 OB/GYN
- 99 Pediatrics

Between 2012 and 2022 primary care FTEs in Vermont declined by 59.1 (13%)

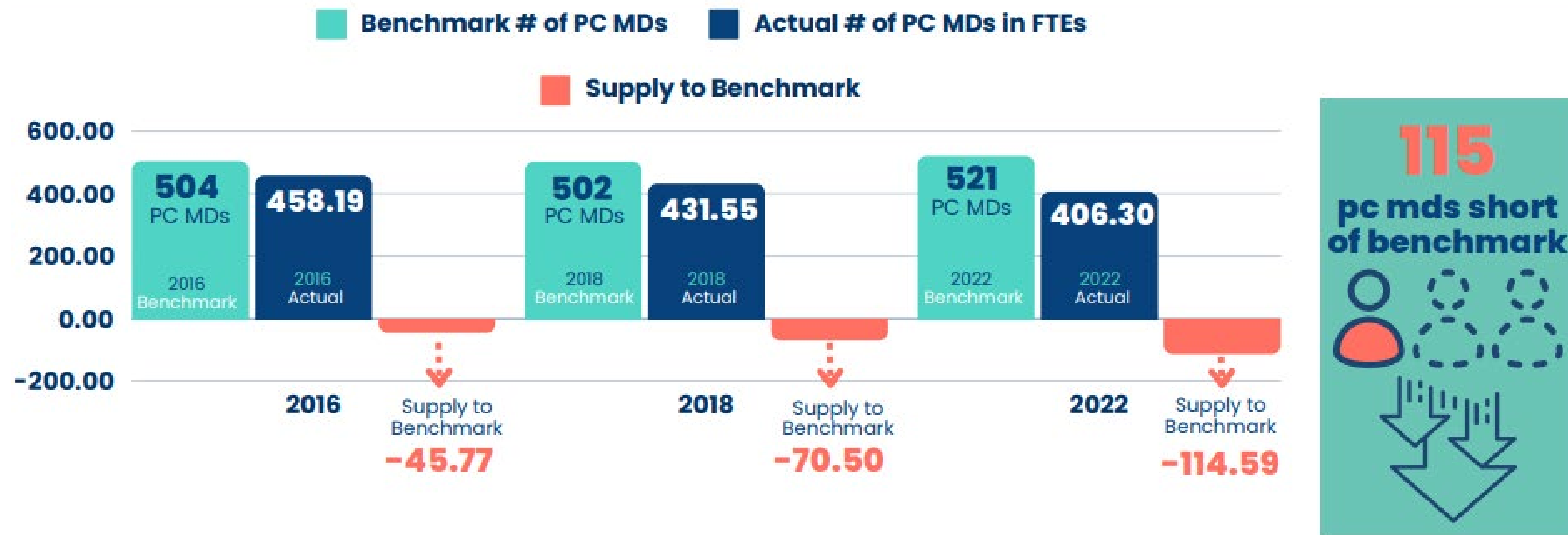
- Over the same period, specialist FTEs went up by 185.2 (23%)

32% of primary care physicians are over age 60, as compared with 29% in 2014, 19% in 2008, and 9% in 2002

- In 5 of the 14 counties, 45% or more of the primary care physicians are over age 60: Lamoille (53%), Essex (50%), Orange (50%), Rutland (47%), and Windsor (46%)

Source: https://www.healthvermont.gov/sites/default/files/document/HSI-stats-prov-phys22-detail.PDF

Vermont's Primary Care Shortage - State Level *2022*



Compared to the 2022 National Benchmarks, Vermont's Primary Care Shortage is 115, which represents a 22% gap.

Full data and analysis available at:
https://vtmd.org/client_media/files/VMS%20Primary%20Care%20Workforce%20Shortage%2020254.pdf

Vermont Department of Health

Physician Assistants

2024 Census

Statistical Report

100 (24% of total or 76.4 FTEs) of PAs work mainly in primary care including:

- 83 Family Practice Medicine
- 10 Primary Care Internal Medicine
- 1 Obstetrics and Gynecology
- 6 Pediatric Primary Care

Between 2014 and 2024, the number of physician assistants in primary care decreased from 103 to 100 (80 FTEs to 76.4FTEs)

- number in specialty care doubled from 161 to 322

Source: https://www.healthvermont.gov/sites/default/files/document/HSI-stats-prov-pa24-detail.pdf

Vermont Department of Health

Advanced Practice

Registered Nurses (APRNs)

2023 Census

Statistical Report

456 (46% of total or 323.5 FTEs) of the APRNs work mainly in primary care, including:

- 90 - Adult Health
- 181 - Family Health
- 34 - Gerontology
- 40 - Pediatric Primary Care
- 23 - School Health
- 88 - Primary Care Women's Health

Between 2015-2023, APRNs in Primary Care grew from 276-456

- Specialty care grew from 259 to 537

Source: https://www.healthvermont.gov/sites/default/files/document/HSI-stats-prov-aprn23-detail.pdf

ADMINISTRATIVE BURDEN

Vermont Medical Society

HEALTH FIRST

2024 Vermont Clinician & Administrator
Prior Authorization Baseline Impact Survey Results

January 15, 2025

Survey Highlights

"I've lost 3 nurses in 2 years that said the main reason they were quitting was because of prior authorizations and the burden and frustration and moral injury they are causing to staff and ultimately patient care."

PAs are time consuming:

- Clinicians report they complete **21.4 authorizations per week** and spend **15.13 hours** on these authorizations
- Administrators report **52.66 hours of ordering provider time** and **27.21 FTEs of additional staff time** spent on PAs each week in their practice

PAs are increasing:

- 77% of clinicians/94% of administrators say the number of PAs for medications have increased in the last year; 64% of clinicians/77% of administrators report PAs for medical services have increased

PAs harm patients and clinicians

- 95% of clinicians report that PAs lead to **higher utilization of health care resources** such as additional office visits or ED visits and 81% that it **delays access to necessary care**; 32% report that it has led to a **serious adverse event** such as hospitalization or death
- **99% of clinicians and 100% of administrators report that PAs increase burnout**

Ann Intern Med. 2016 Dec 6;165(11):753-760. doi: 10.7326/M16-0961. Epub 2016 Sep 6.

Allocation of Physician Time in Ambulatory Practice: A Time and Motion Study in 4 Specialties

Christine Sinsky [1], Lacey Colligan [1], Ling Li [1], Mirela Prgomet [1], Sam Reynolds [1], Lindsey Goeders [1], Johanna Westbrook [1], Michael Tutty [1], George Blike [1]

Conclusion: For every hour physicians provide direct clinical face time to patients, nearly 2 additional hours is spent on EHR and desk work within the clinic day

Am J Public Health. 2003 Apr;93(4):635-641. doi: 10.2105/ajph.93.4.635

Primary Care: Is There Enough Time for Prevention?

Kimberly S H Yarnall [1], Kathryn I Pollak [1], Truls Østbye [1], Katrina M Krause [1], J Lloyd Michener [1]

Results: To fully satisfy the USPSTF recommendations, 1773 hours of a physician's annual time, or 7.4 hours per working day is needed

Rank	Preventive Service	Annual Frequency	Minutes Per Service	Hours Per Year
	Screening			
A	Blood pressure	1.00	0.25	6.7
A	Papanicolaou test50,[a]	0.33	3.00	14.0
A	Mammogram[b]	0.50	1.00	2.4
A	Clinical breast exam22,[b]	1.00	6.00	29.0
B	Height and weight check	1.00	0.25	6.7
B	Total blood cholesterol[c]	1.00	1.00	12.0
B	Fecal occult blood test[d]	1.00	1.00	12.0
B	Sigmoidoscopy28–31,[d]	0.25	17.00	49.0
B	Assess for problem drinking51,52	1.00	0.50	13.0
B	Rubella serology[e]	0.10	1.00	0.8
B	Vision screening[f]	1.00	1.00	5.3
B	Assess for hearing impairment[f]	1.00	1.00	5.3
	Counseling			
A	Tobacco cessation21,[g]	1.00	3.00	19.0
A	Regular physical activity54,[h]	1.00	4.00	108.0
A	Lap/shoulder belt35	1.00	1.50	40.0
A	Motorcycle/bike/ATV helmet[h]	1.00	1.50	40.0
B	Problem drinking23–27,[i]	1.00	5.00	14.0
B	Driving while intoxicated[h]	1.00	3.00	81.0
B	Limit fat and cholesterol/diet36,56	1.00	8.20	221.0
B	Adequate calcium intake[a]	1.00	1.50	21.0
B	STD prevention[h]	1.00	3.00	81.0
B	Contraception[j]	1.00	3.00	62.0
B	Smoke detector[h]	1.00	1.50	40.0
B	Safe storage/removal of firearms[h]	1.00	1.50	40.0
B	Visits to dental care provider[h]	1.00	1.50	40.0
B	Floss, brush daily[h]	1.00	1.50	40.0
B	Fall prevention[f,h]	1.00	1.50	7.9
B	Hot water heater set < 120–130°F[f,h]	1.00	1.50	7.9
Immunizations				
A	Td booster	0.10	0.50	1.3
B	Rubella[e]	0.10	0.50	0.4
B	Pneumococcal vaccine[f]	1.00	0.50	2.6
B	Influenza[f]	1.00	0.50	2.6
Chemoprophylaxis				
B	Multivitamin with folic acid[e]	1.00	1.50	12
B	Discuss hormone prophylaxis[k]	1.00	4.00	25
Total hours required per year				1067
Total hours required per working day				4.4

PATIENT ACCESS

Medical Health Care Access – Provider

Nine in 10 Vermont adults report having a personal health care provider (PCP) (90%), statistically higher than the 83% of U.S. adults.

Females are statistically more likely to have a PCP.

Adults 65 and older are statistically more likely to have a PCP than younger adults. Adults 45-64 are statistically more likely to have a PCP than adults 25-44.

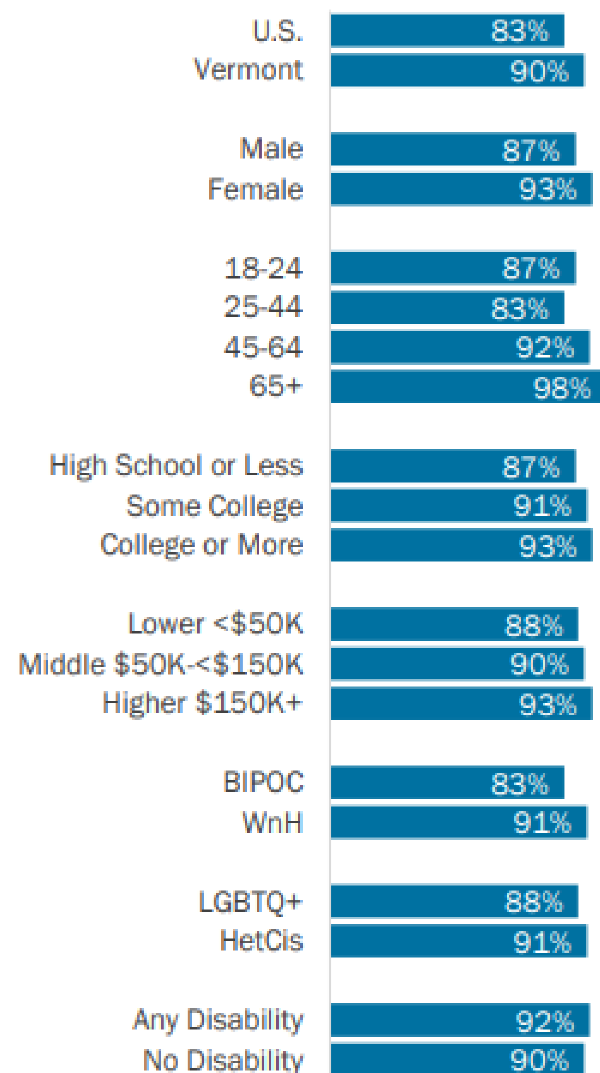
Adults with a college degree or more are statistically more likely to have a PCP than those with a high school education or less.

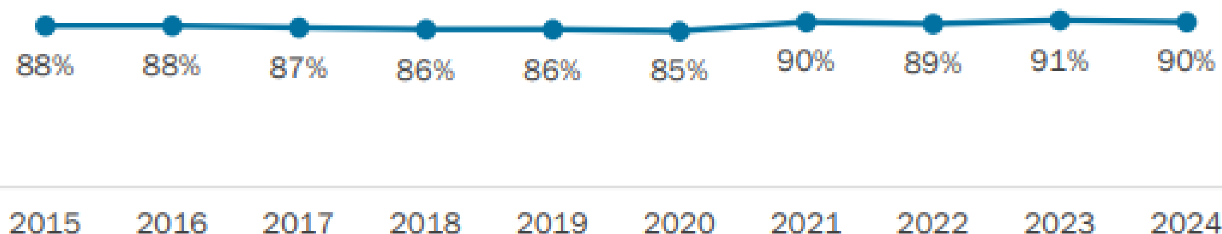
Adults in higher income homes are statistically more likely to have a PCP than those in lower income homes.

White, non-Hispanic adults are statistically more likely to have a PCP.

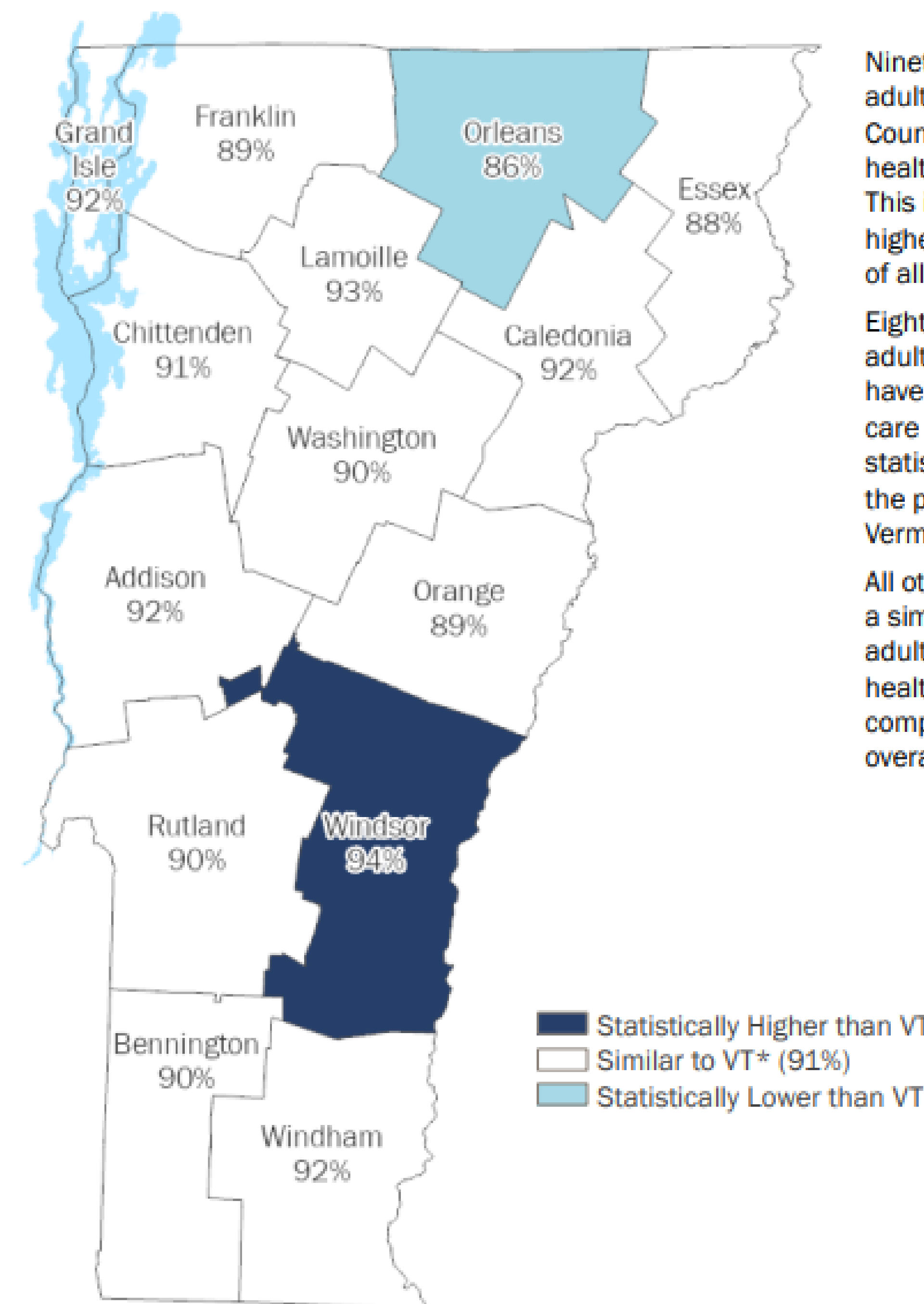
Having a PCP is not statistically different by sexual orientation and gender identity, or disability status.

The percent of Vermont adults with a PCP is statistically similar to 2023, but statistically higher than 2015.





Vermont Adults with a Personal Health Care Provider by County, 2023-2024



Ninety-four percent of adults in Windsor County have a personal health care provider. This is statistically higher than the percent of all Vermont adults.

Eighty-six percent of adults in Orleans County have a personal health care provider. This is statistically lower than the percent of all Vermont adults.

All other counties have a similar percent of adults with a personal health care provider compared to Vermont overall.

*Vermont estimate represents two years of data.

Medical Health Care Access – Delay Due to Cost

Eight percent of Vermont adults say there was a time in the past year they did not go to the doctor because of cost. This is statistically lower than the 12% of U.S. adults.

Males and females report not seeing a doctor due to cost at statistically similar rates.

Adults 25-44 are statistically more likely to delay medical care due to cost than those 45-64. Adults 65 and older are statistically less likely to delay medical care due to cost than younger adults.

Adults with some college or less are statistically more likely to delay medical care due to cost than those with a college degree or more.

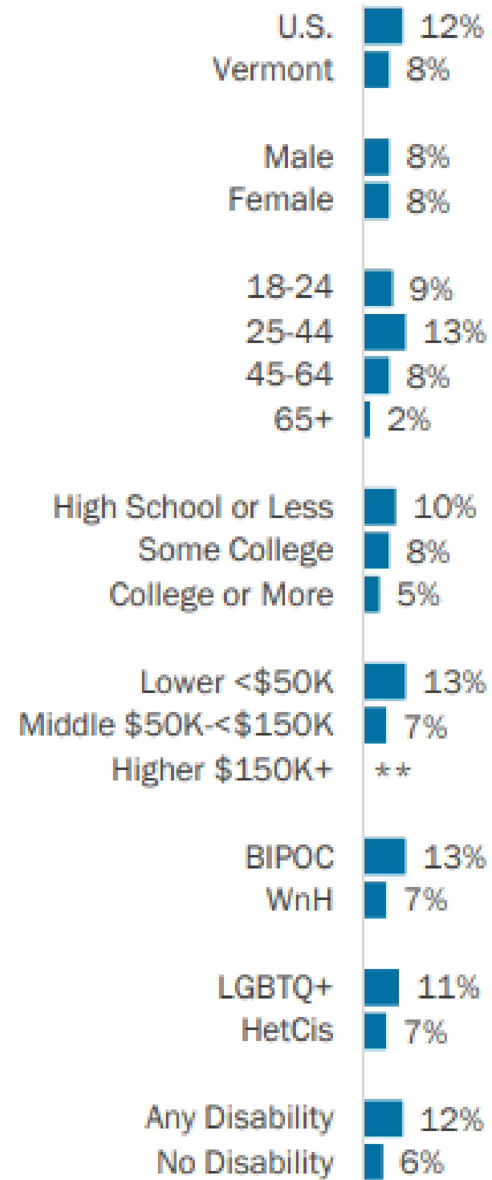
Adults in lower income homes are statistically more likely to delay care due to cost than those in middle income homes.

BIPOC adults are nearly two times as likely to delay care due to cost than white, non-Hispanic adults. This is a statistical difference.

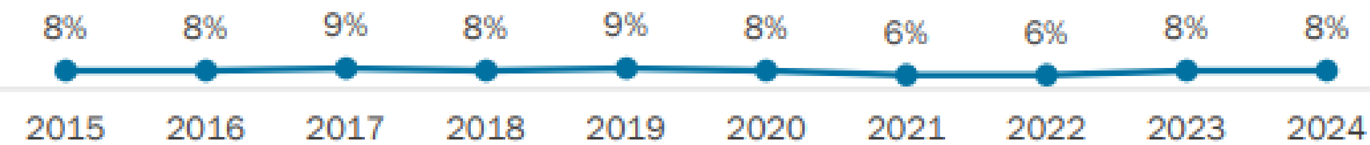
LGBTQ+ adults are statistically more likely to delay care due to cost than HetCis adults.

Adults with a disability are two times as likely to delay care due to cost than adults with no disability. This is a statistical difference.

The percent of Vermont adults delaying medical care due to cost is the same as 2023 and 2015.

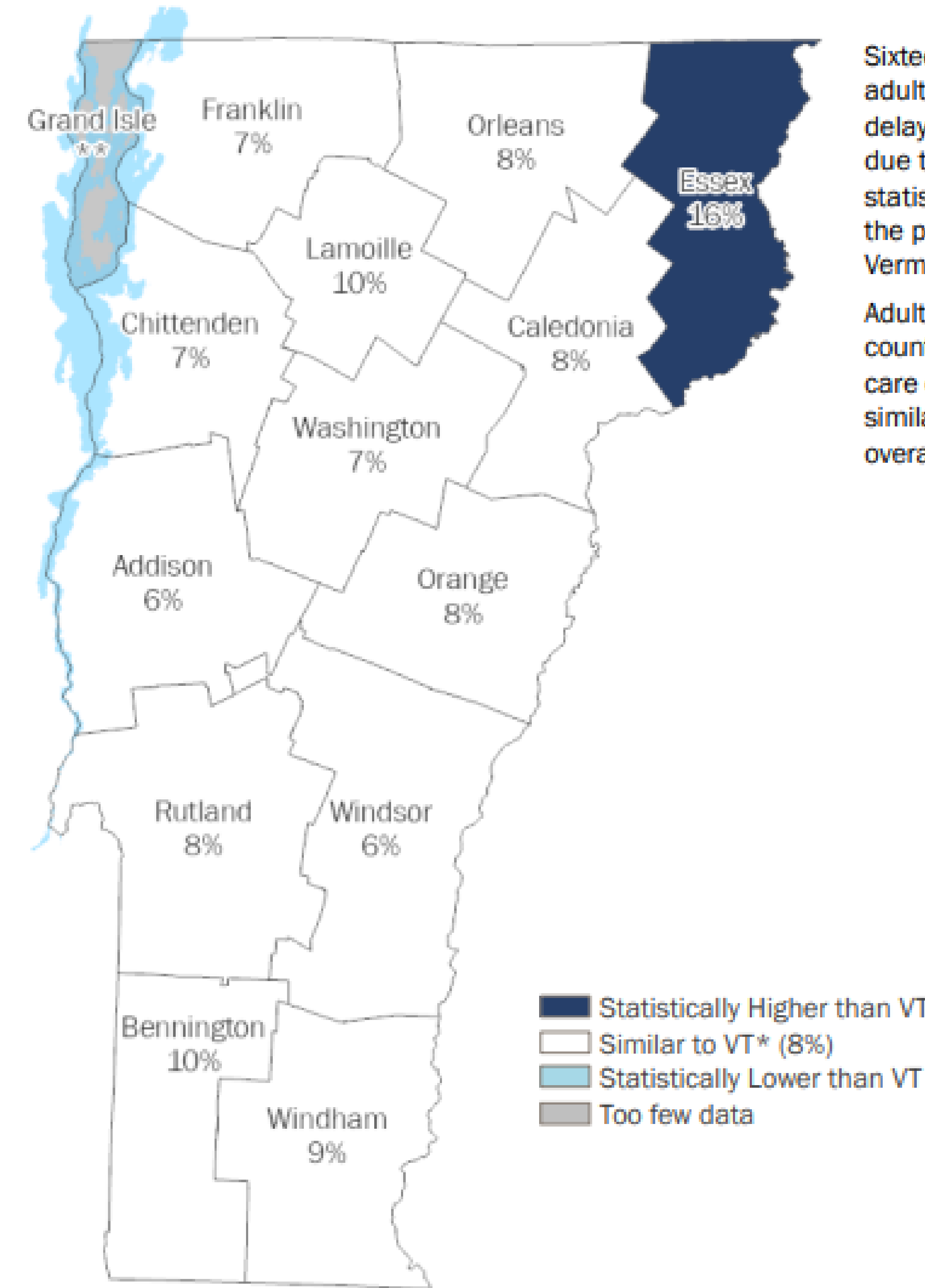


Vermont Adults Who Did Not Visit Doctor Due to Cost



Note: This measure is a Healthy Vermonters 2030 indicator.
**Value suppressed because sample size is too small or relative standard error (RSE) is >30. Statistical comparisons are not completed on suppressed values.

Vermont Adults Who Did Not Visit Doctor Due to Cost by County, 2023-2024



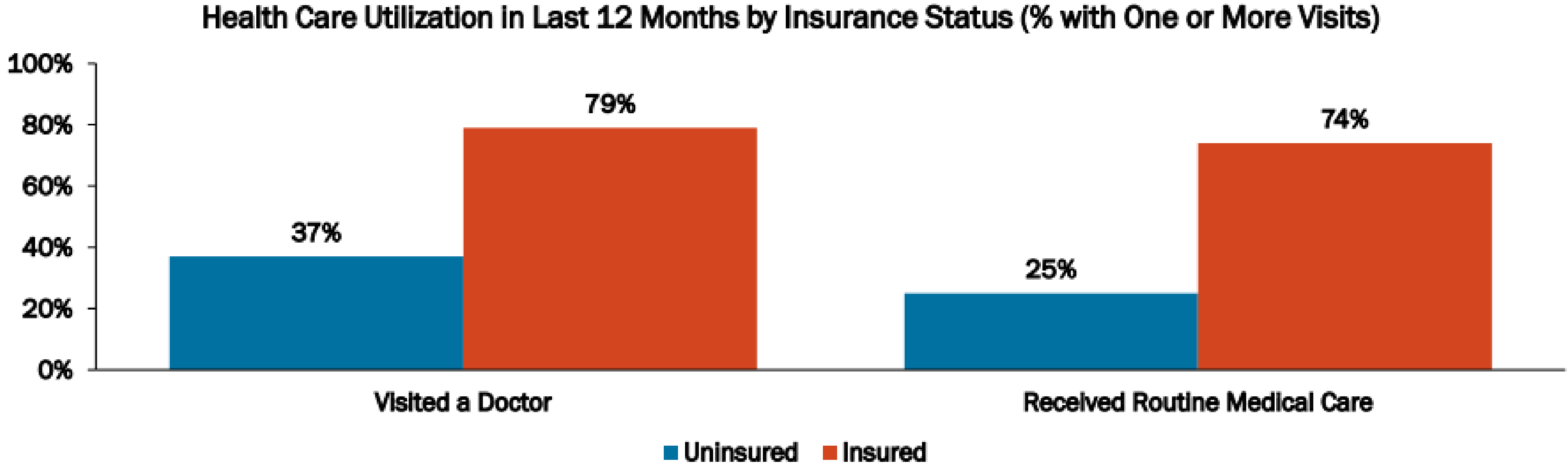
Sixteen percent of adults in Essex County delayed medical care due to cost. This is statistically higher than the percent of all Vermont adults.

Adults in all other counties delay medical care due to cost at a similar rate to Vermont overall.

*Vermont estimate represents two years of data.
**Value suppressed because sample size is too small or relative standard error (RSE) is >30. Statistical comparisons are not completed on suppressed values.

Health Care Utilization in Last 12 Months by Insured Status

In 2025, almost eight in ten (79%) insured Vermont residents had visited a doctor in the last 12 months, compared to just 37% of uninsured Vermont residents, a significant difference.



	Estimated Population by Insurance Status	
Type of Care	Uninsured	Insured
Visited a Doctor	7,700	489,500
Received Routine Medical Care	5,100	457,200

Source: 2025 Vermont Household Health Insurance Survey, https://www.healthvermont.gov/sites/default/files/document/hsi-hhis-2025-report.pdf

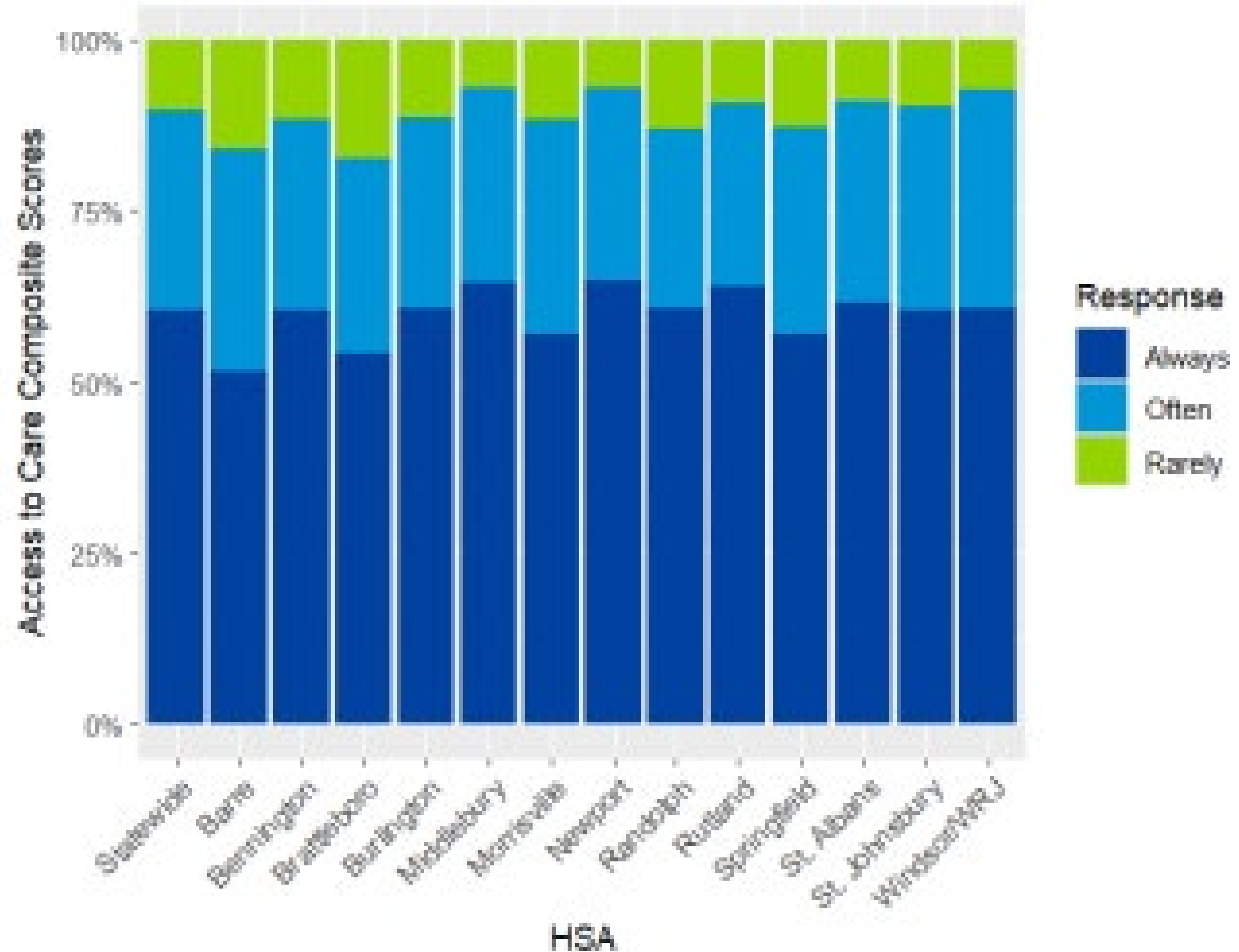
PATIENT EXPERIENCE: 2024 CONSUMER ASSESSMENT OF HEALTHCARE PROVIDERS SURVEY (CAHPS) RESULTS

Blueprint for Health
Vermont Agency of Human Services

July 2025

https://blueprintforhealth.vermont.gov/sites/bfh/files/documents/2024_CAHPS_Summary_Report_0.pdf

- In the last year, 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 year, 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 year, when you contacted this provider's office during regular office hours, how often did you get an answer to your medical questions that same day?



Over the past five years, the trend for the Access to Care composite measure has been downward, indicating an overall statewide decrease in patients rating of the questions. In 2024, the trend leveled. This trend is consistent with nationwide health care workforce shortages caused by increasing rates of retirement and resignation among providers. Figure 3, below, shows the five year mean trend for the Access to Care composite measure.

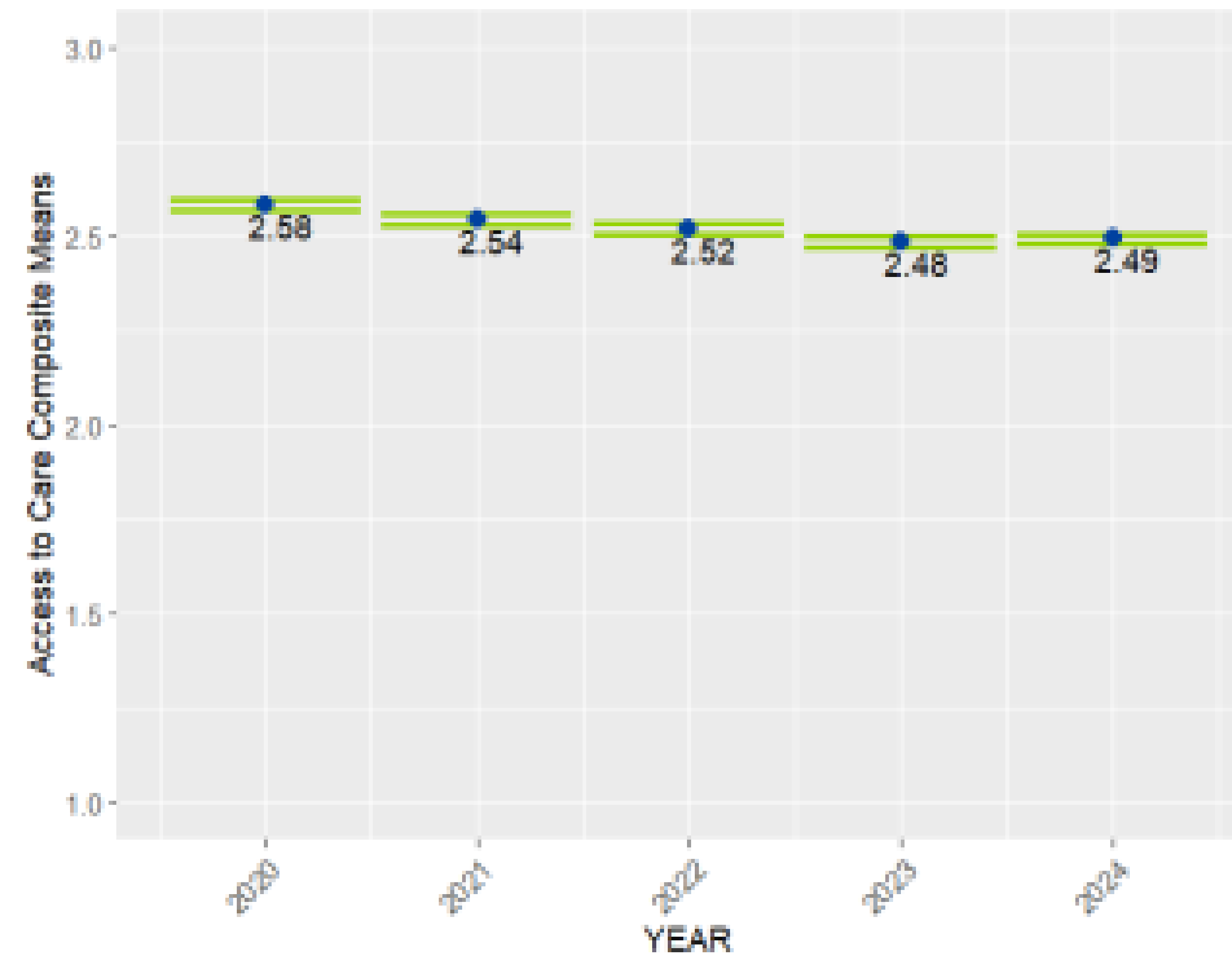


Figure 3. Five-year trend in statewide Access to Care composite measure mean scores.

Access & Panel Size

Determining Patient Panel Size in Primary Care: A Meta-Narrative Review

Abd Moain Abu Dabrh [1], Wigdan H Farah [2], Heidi M McLeod [1], Parisa Biazar [3], Arya B Mohabbat [2], Bala Munipalli [1], Rachel Garofalo [4], Robert J Stroebel [2], Nilay Shah [2], Kurt B Angstman [2], Richard J Presutti [1], Bryan Farford [1], Jennifer L Horn [2], Summer V Allen [2], Adam I Perlman [1], Ana Lucia Chong Lau [1], Larry J Prokop [2], M Hassan Murad

Determining the ideal PPS is a multifaceted process influenced by practice setting, patient demographics, and clinician characteristics.... Primary care practices should tailor panel sizes to their patient populations, emphasizing a patient-centered approach and ensuring adequate infrastructure support to optimize care delivery…In the current state, **it is not feasible to confidently establish optimal PPS for a given practice based on well-established norms or via an extensive review of the literature**

UC Health

Center For Health Quality And Innovation

Calculating Primary Care Panel Size

January 2017

The literature demonstrates some accepted and novel methods for establishing the right-sized panel. Non face-to-face care, risk adjustment, and the effectiveness of the practice team must be considered in establishing a targeted panel size.

Evidence Synthesis Program

What is the Optimal Panel Size in Primary Care? A Systematic Review

August 2019

Prepared for:
Department of Veterans Affairs
Veterans Health Administration

Authors:
Principal Investigator:
Paul G. Shekelle, MD, PhD

The evidence about the effect of panel size on the Institute of Medicine aims for health care improvement is surprisingly thin, given the importance of primary care panel size to all models of population-based care. The few studies available provide a signal that increasing panel size may have an **association with modest worsening of clinical quality and patient experience**. Several modeling studies exist, but all model only the effect of panel size on access to care, and assume that other IOM aims are constant with increasing panel size. **Modeling studies support the policy that risk-adjustment and practice-level variables influence the optimal panel size for access. Current recommendations regarding primary care panel size are based more on historical experience than on evidence.**

Self-Reported Panel Size Among Family Physicians Declined by Over 25% Over a Decade (2013-2022)

Andrew Bazemore, Zachary J. Morgan and Kevin Grumbach

The Journal of the American Board of Family Medicine May 2024, 37 (3) 504-505; DOI: https://doi.org/10.3122/jabfm.2023.230421R1

"The many potential factors may include task-shifting of less complex patients and visits to urgent care, Nurse Practitioner & Physician Assistant team members that increase overall physician panel complexity and time demands, emphasis on value-based payment and reporting, burnout, hours worked, and changing physician demographics."

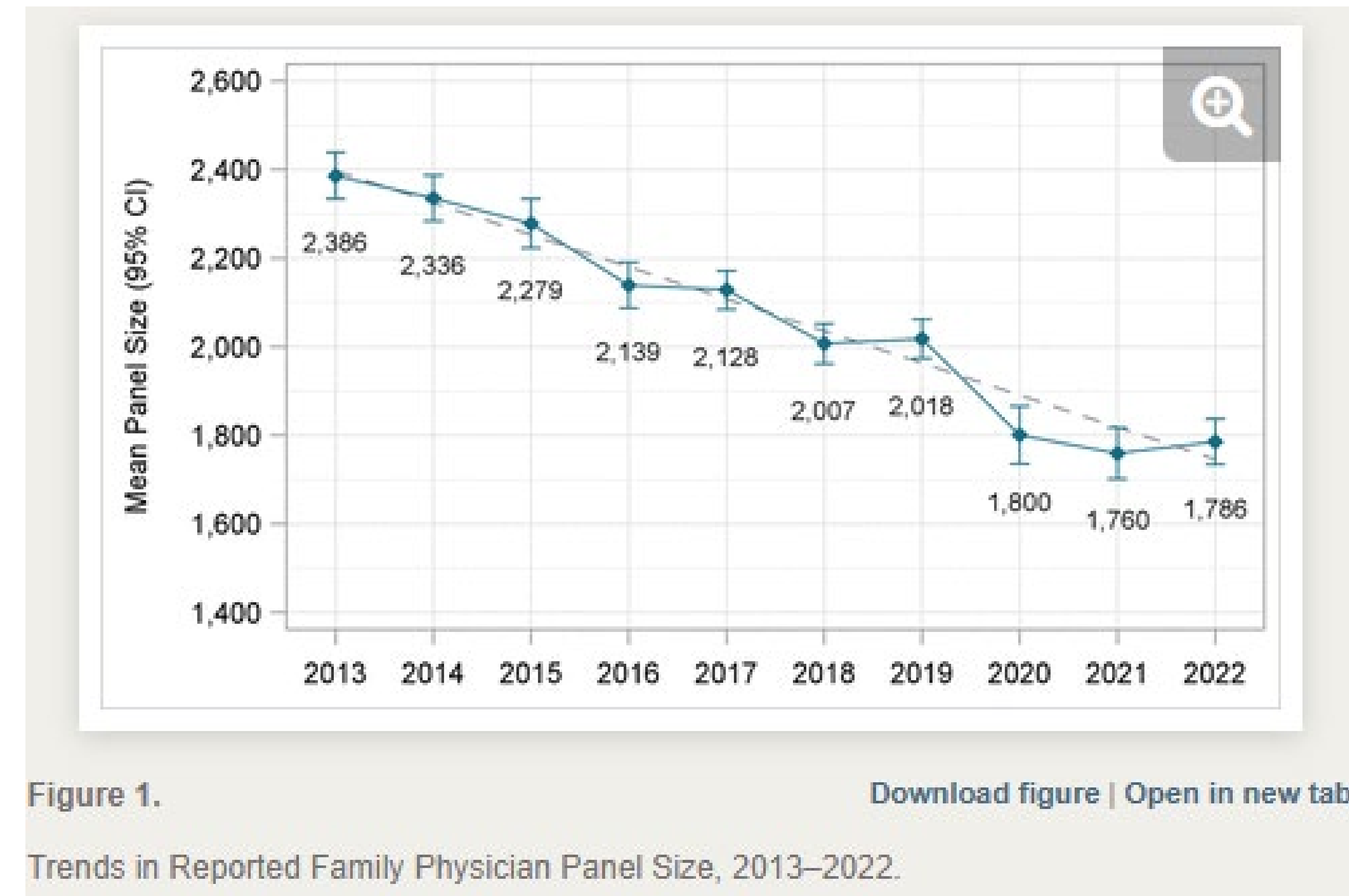


Figure 1.

Trends in Reported Family Physician Panel Size, 2013–2022.

VMS 2023 inquiry: 1200, 1300, 2100, 2-2400, 2800

Questions?