Connecticut Health Policy Project

POLICYMAKER ISSUE BRIEF

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Patient-centered medical homes: How could they help Connecticut?

Patient-centered medical homes are gaining attention at the state and federal level as one of the few reform options that will both improve the quality of care and reduce its cost. In 2006, there were 47,640 hospitalizations in CT that could have been prevented with better access to coordinated primary care. Less than half of CT residents over age 50 receive recommended screenings and preventive care.

Medical homes are not buildings or hospitals, but a different way of providing health care. Medical homes offer coordinated, comprehensive primary health care that is accessible, continuous, compassionate and culturally appropriate.

- Providers work in teams, with each member working at the top of their training.
- Care is coordinated with specialists, hospitals, labs and pharmacy. This reduces duplicate care and prevents errors.
- Medical homes provide after-hours access to care.
- Care is coordinated with the help of technology to ensure that providers have all the information they need to provide the best care.
- Medical homes support primary care providers in their work. Fewer physicians are choosing to practice primary care causing a serious shortage that is growing.

The most important determining feature of a medical home is that care is **patient-centered**. As an administrator from an accredited medical home put it, "Everything swirls around the patient."

- Patients take a primary role in making decisions about their care.
- Patients are expected to be active participants in choosing their treatments and in staying healthy.
- Patients receive preventive care, disease management, support and other tools to help them maintain their health.
- Patients are surveyed regularly about their experiences with the medical home.

CT HEALTH POLICY PROJECT
Phone: 203.562.1636
FAX: 203.562.1637
Web: www.cthealthpolicy.org

Thirty seven states and many other countries have medical home model programs. Connecticut has included the medical home model into our HUSKY program with the Primary Care Case Management plan. Private payers, especially large companies, have embraced the medical home model with funding and technical assistance. Medicare is sponsoring medical home pilot projects across eight states this year.

There is ample evidence that improving access to primary care reduces costs by reducing hospital admissions, reducing overtreatment, and preventing disease. Coordinating care and use of health information technology have enormous potential to stem skyrocketing health care costs. It is estimated that health information technology could save the US health care system between $142 and 371 billion annually. Statewide implementation of Primary Care Case Management could save CT over $100 million/year.

CT policymakers can help promote medical homes across the state's roles in health care.

- Support and expand Primary Care Case Management as an option for every HUSKY family. HUSKY is CT's largest purchasing pool.
- Promote the development of medical homes for other state-covered populations including state employees, SAGA, and Medicaid. In all, CT provides coverage to one in five state residents.
- Set standards, recognize, pilot and evaluate medical homes in CT.
- Provide technical assistance to practices willing to do the hard work of transforming to the medical home model of care.
- Convene other payers and providers to encourage collaboration to build a strong, sustainable foundation for medical homes in CT.

Bottom Line:

Medical homes have great potential to both improve the quality of care in Connecticut and to reduce its cost.

Sources:
R Hillestad, et al, Health Affairs 24:1103, 2005; Patient-centered medical homes, National Partnership for Women and Families, www.nationalpartnership.org; Commonwealth Fund State Scorecards, www.cmwf.org; CT Heath Policy Project, www.cthealthpolicy.org/medicalhome