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**State Medical
Home Initiatives:
where are we
now?**

February 2010

General Characteristics of a Patient Centered Medical Home Initiative

Entity is a primary care provider (MD, NP, clinic)

Emphasis is improving availability and quality of primary care, and coordination of patient care

Most initiatives are pilot or demonstration projects

Target patient population is chronically ill or medically complex patient, at least initially

Generally assumes PCMH is operating in FFS environment and participating in multiple insurance programs

State/purchaser objectives

- ~ Better health care outcomes for patients
- ~ Reduce, or at least limit growth, in health care costs
- ~ Enhance coordination of care, including making effective use of community resources such as patient education programs, self-management training, social services networks
- ~ Greater patient satisfaction with access and quality of care

Provider objectives

- ~ Better health care outcomes for patients
- ~ Greater staff satisfaction with role via team structure, use of each team member to limit of license
- ~ Physician enjoys job more/again
- ~ Quality of practice's performance is supported and rewarded by increased revenue, perhaps other forms of recognition (high scores on patient surveys, favorable comparisons with peers on public reports, greater market share)

Patient objectives

- ~ Have regular source of care from team that is readily accessible, knowledgeable, efficient, compassionate, recognizes my needs and family situation, and helps me maintain or improve my health and that of my family
- ~ Keep my personal health care costs as low as possible

PCMH characteristics vary widely

Payment mechanisms:

- Some supplemental payment in addition to FFS (generally \$3-6 PMPM, adjusted for age, other)
- Bonus for meeting certain performance measurement targets
- Shared savings (provider and state)

Quality measures:

- Reduction in ER use, inpatient admissions, brand Rx
- Scores on patient experience surveys
- HEDIS clinical measures

Characteristics (cont'd)

Requirements to qualify as PCMH:

- Achieve recognition by NCQA using their PCC-PCMH tool (used either as threshold requirement or must meet within a certain time frame)
- Special state-specific requirements can include practice agreeing to participate in learning collaboratives, provide state with certain data, install and use certain electronic health information systems, involve patients in practice improvement activities

Transitioning to PCMH can require:

- ~ IT systems installation or enhancement (often w/ payer financial incentives)
- ~ IT training support (staff and clinicians)
- ~ Participating in learning collaboratives
- ~ Establishing or locating appropriate patient education/self management support programs
- ~ Enhancement of data sharing through electronic exchange, including putting in place special agreements with regard to privacy and security

Recent developments and news from your neighbors

- ~ Massachusetts released its PCMH design and implementation framework Nov. 2009
- ~ NYS partnering with a CHC network on PCMH model and also promoting PCMH throughout state using IT incentives
- ~ Vt. working with federal DHHS to bring Medicare in as a partner in the Vt. chronic care PCMH pilot
- ~ DHHS has approved North Carolina Medicaid agency request to expand its statewide PCMH to dual eligibles, sharing savings w/ federal, state, and practices

Some thoughts from the front line

- ~ Change is hard – strong, sustained leadership is critical
- ~ Change takes time – don't overpromise
- ~ Change takes investment, both upfront and sustained
- ~ BUT doctors love it, patients love it, and early research results suggest it can also save money while improving quality and access to care





thank you

Lee Partridge
Senior Health Policy
Advisor