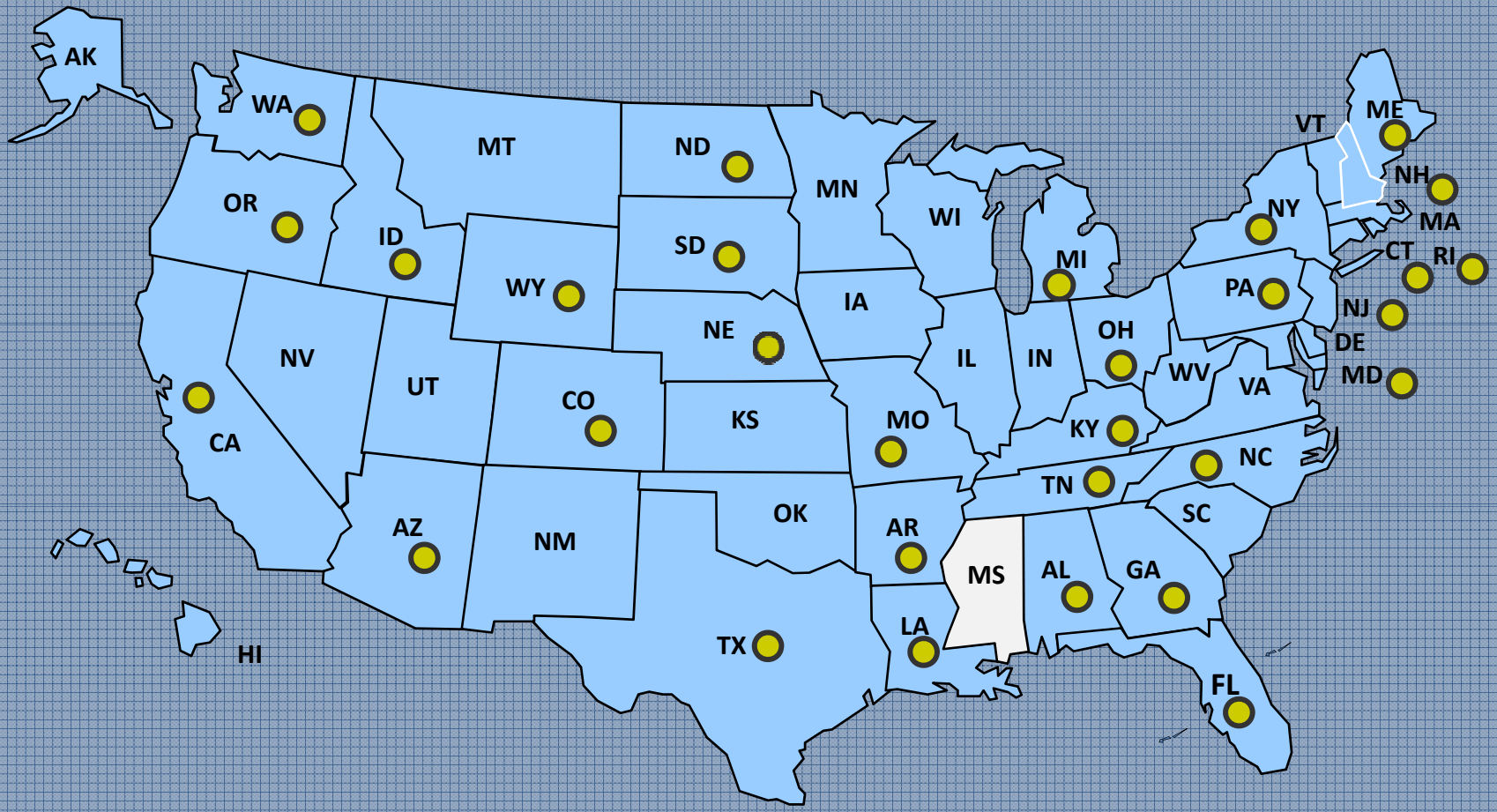
The Patient-Centered Medical Care: From Vision to Reality

Melinda Abrams, M.S.
The Commonwealth Fund

GIH Fall Form
November 16, 2012

Spread of Medical Home Pilots: Commercial Health Plan Activity



Multi-Payer pilot discussions/activity (30 states)

Identified pilot activity (49 states)

No identified pilot activity (1 State)

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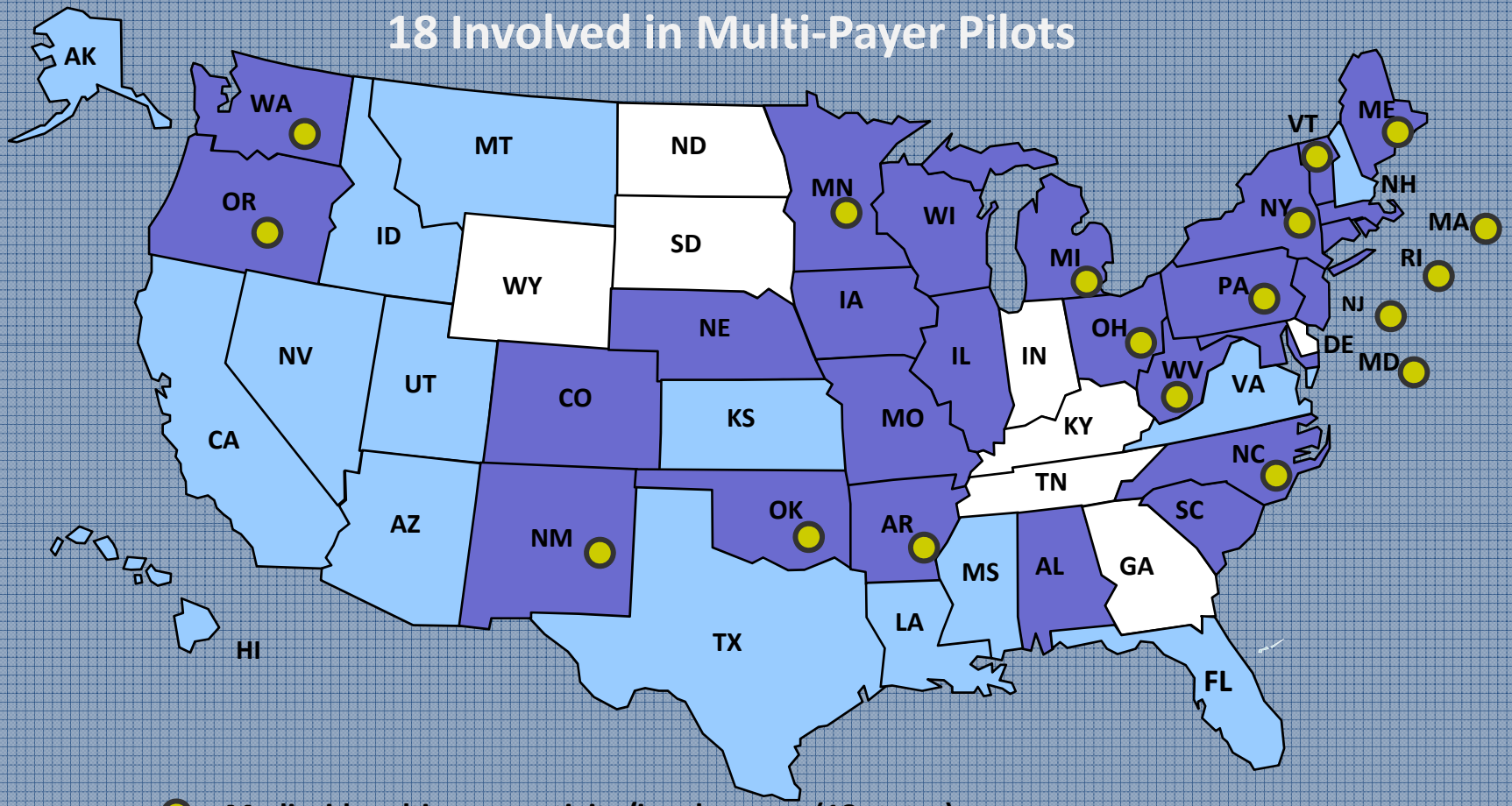
Source: Patient Centered Primary Care Collaborative, updated October 2012

Overview of Medicaid Medical Home Activity

42 State Medicaid/CHIP Programs Planning/Implementing PCMH
27 Making Medical Home Payments
18 Involved in Multi-Payer Pilots



Medicaid multi-payer activity/involvement (18 states)

States making payments for PCMH (27 states)

Significant activity for Medicaid/ CHIP PCMH advancement (15 states)

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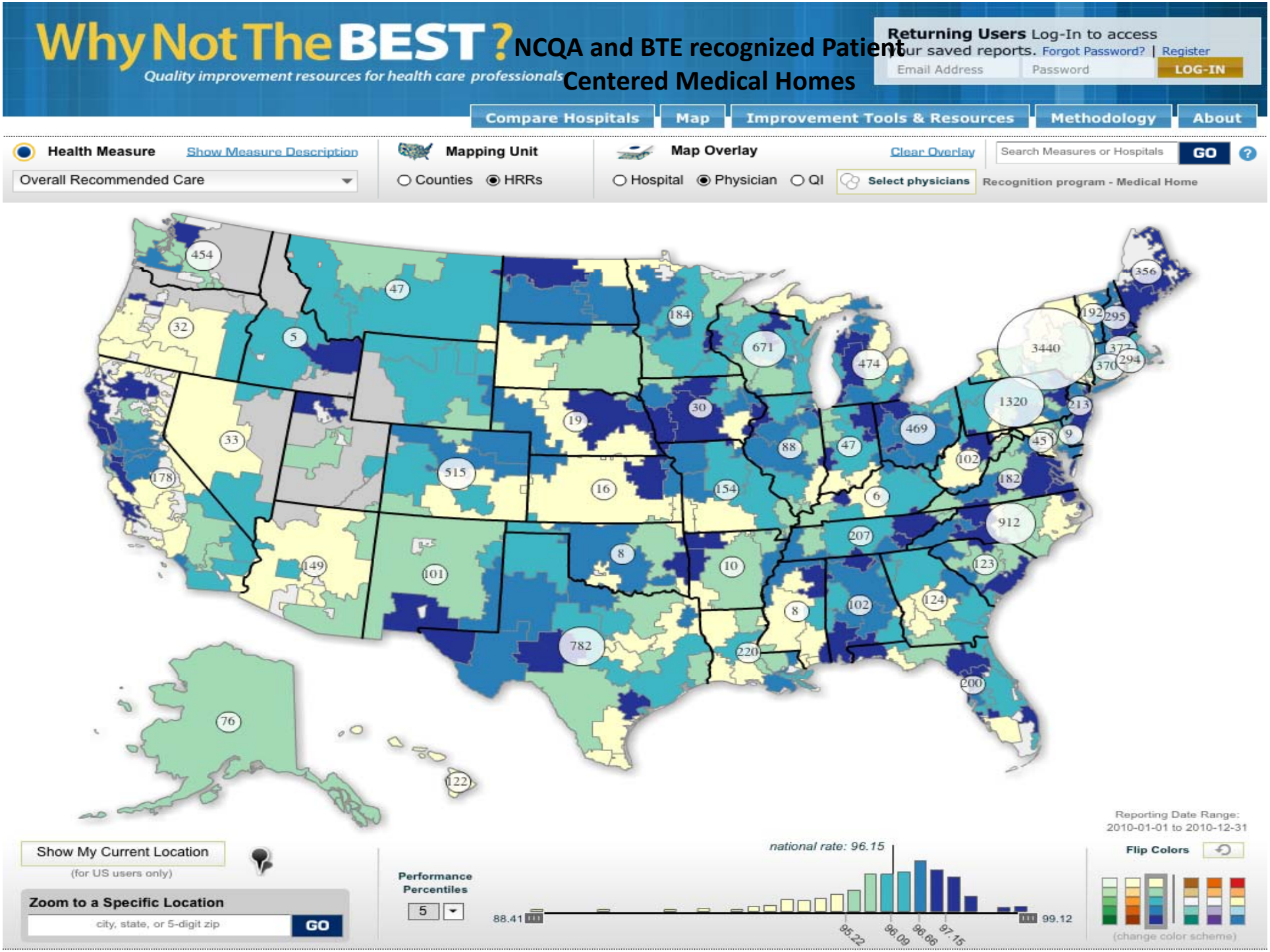
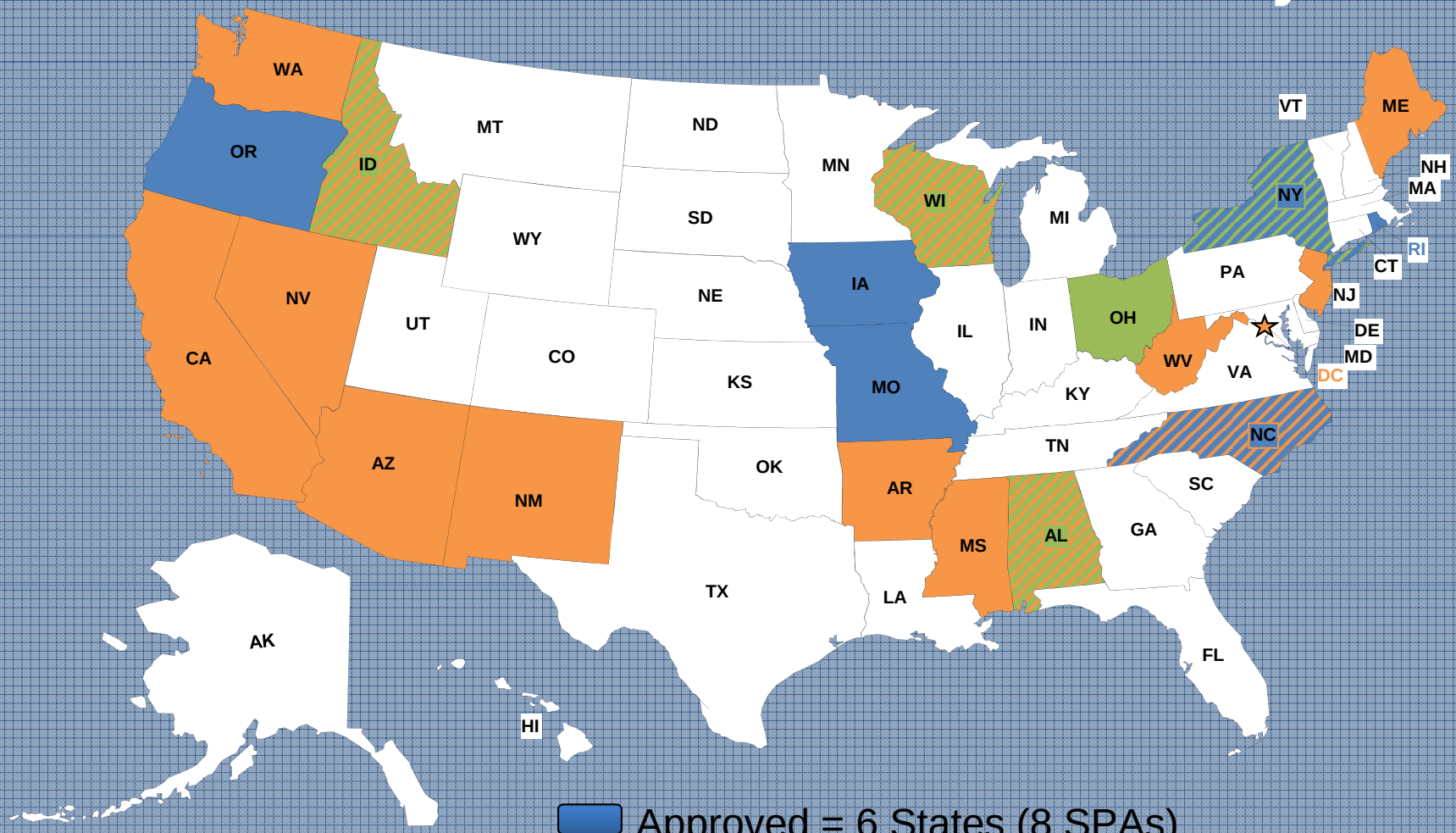
Source: National Academy for State Health Policy State Scan, October 2012. http://www.nashp.org/med-home-map


Why Not The BEST?
Quality improvement resources for health care professionals
NCQA and BTE recognized Patient Centered Medical Homes
Returning Users Log-In to access your saved reports. Forgot Password? | Register
Email Address
Password
LOG-IN
Compare Hospitals
Map
Improvement Tools & Resources
Methodology
About
Health Measure
Show Measure Description
Overall Recommended Care
Mapping Unit
Counties
HRRs
Map Overlay
Clear Overlay
Hospital
Physician
QI
Select physicians
Search Measures or Hospitals
GO
Recognition program - Medical Home
454
47
32
5
184
671
474
3440
356
192
295
372
294
370
1320
213
30
19
469
88
47
45
9
102
33
515
16
154
6
182
178
912
207
8
10
123
149
101
124
102
8
782
220
200
76
122
Show My Current Location
(for US users only)
Zoom to a Specific Location
city, state, or 5-digit zip
GO
Performance Percentiles
5
national rate: 96.15
88.41
95.22
96.09
96.66
97.15
99.12
Reporting Date Range:
2010-01-01 to 2010-12-31
Flip Colors
(change color scheme)

What is the Difference Between a Medical Home and a Health Home?

- Some differences:
  - **Lead clinician** (physician, nurse practitioner)
  - **Focus on integration** (behavioral health, oral health, public health)
  - **patient population** (all, high-risk)
- Affordable Care Act: Section 2703
  - Care for low-income, chronically ill
- Sequence: medical home → health home (??)

Section 2703 Health Home Activity



- Approved = 6 States (8 SPAs)
- Submitted = 5 States
- Planning Grant = 14 States and Washington, D.C.

As of September 15, 2012

Early Lessons from Evaluations

- **With adequate financial support and technical assistance, small practices can adopt medical home structures and processes**
- **Aspirations for cost savings likely reside in better care coordination/care transitions and care management**
  - Need a receptive medical neighborhood
  - "Total cost of care" savings at 2 years is unlikely, unrealistic
- **Technical assistance seems to be most helpful (according to practices) if it is local and on the ground**
- **A sequence of the key changes is beginning to emerge**
- **Broad participation of payers is a major morale boost for sites**
- **ACOs, related payment reforms complement PCMHs**

Goals of the Session

Take a deep dive on key issues to help guide PCMH implementation

- What are the barriers to PCMH transformation?
- What is critical for successful PCMH implementation?
- What assistance do safety net sites need and/or want to support transformation?
- Given the value of care management for high-risk, vulnerable patients, what do those programs look like? How do they vary for low-income populations?

Panelists

Sarah Hudson Scholle, Dr.P.H
National Committee for Quality Assurance

Kathryn Phillips, MPH
Qualis Health
Safety Net Medical Home Initiative

Clemens Hong, MD, MPH
Massachusetts General Hospital