Patient Centered Primary Care Collaborative

and the National Patient Centered Medical Home Movement

February 2011

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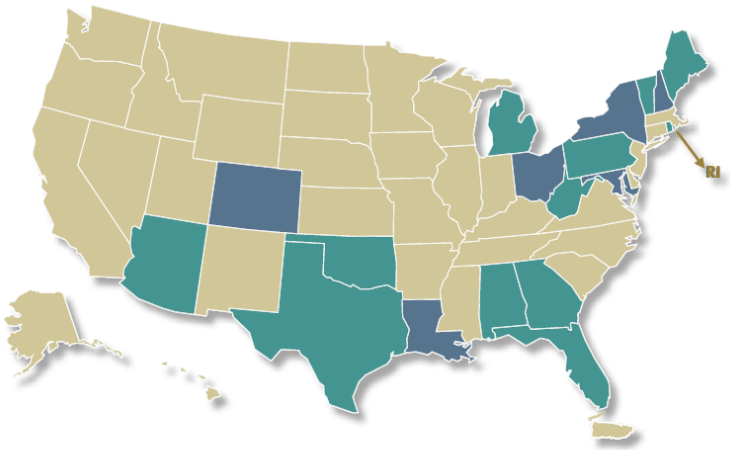
Table of Contents

Patient-Centered Primary Care COLLABORATIVE

Overview of Activity

- 27 Large Multi-stakeholder and other Pilots in 18 States
- 44 States and the District of Columbia Have Passed over 330 Laws and/or Have PCMH Activity
- Medicaid and Medicare Activity



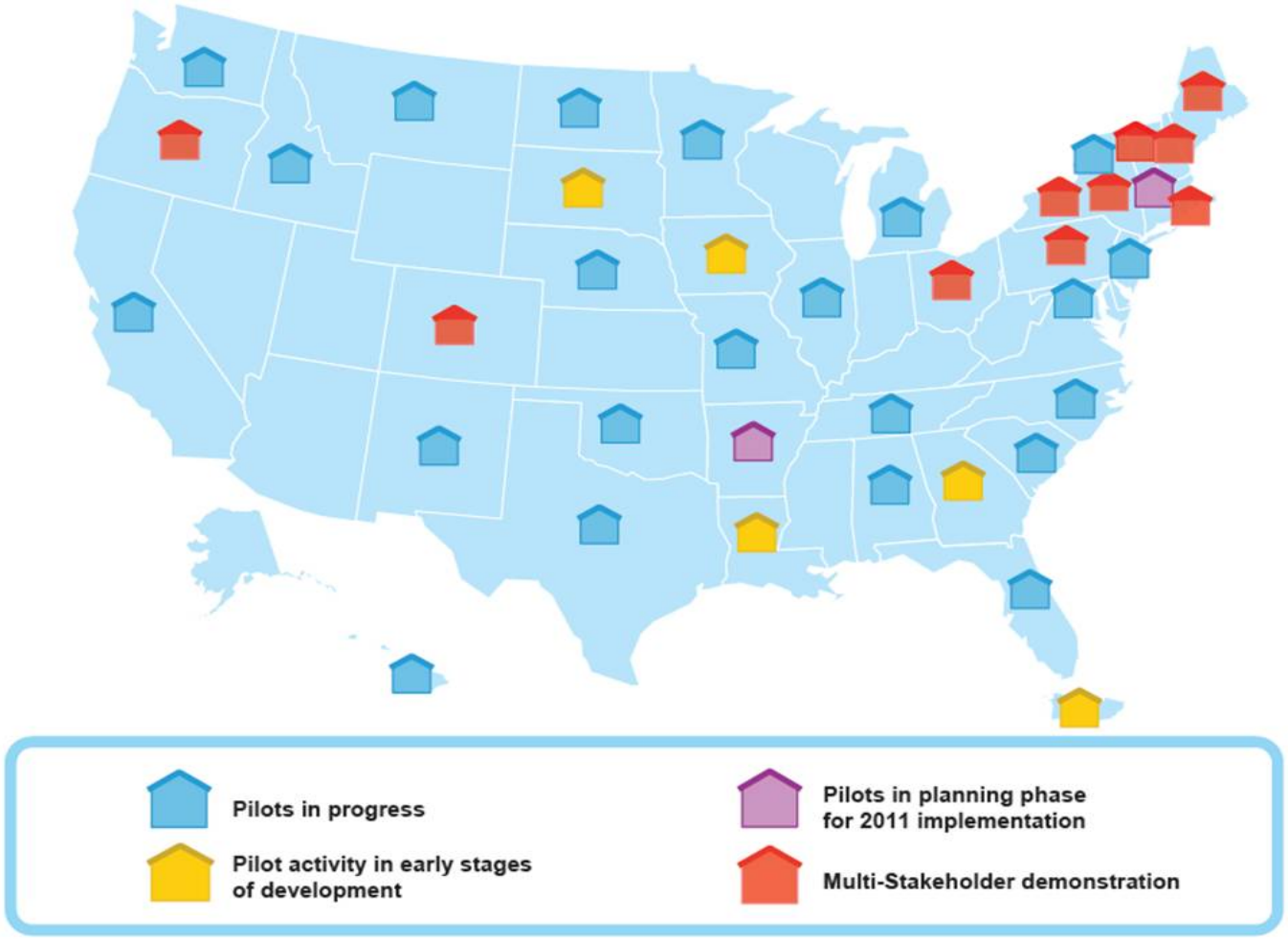
- Alabama Health Improvement Initiative—Medical Home Pilot (AL)
- UnitedHealth Group PCMH Demonstration Program (AZ)
- The Colorado Multi-Payer, Multi-State Patient-Centered Medical Home Pilot (CO)
- Colorado Family Medicine Residency PCMH Project (CO)
- MetCare of Florida/Humana Patient-Centered Medical Home (FL)
- WellStar Health System/Humana Patient-Centered Medical Home (GA)
- Greater New Orleans Primary Care Access and Stabilization Grant (PCASG) (LA)
- Louisiana Health Care Quality Forum Medical Home Initiative (LA)
- Maine Patient-Centered Medical Home Pilot (ME)
- CareFirst BlueCross BlueShield Patient-Centered Medical Home Demonstration Program (MD)
- National Naval Medical Center Medical Home Program (MD)
- Blue Cross Blue Shield of Michigan—Physician Group Incentive Program (PGIP) (MI)
- Priority Health PCMH Grant Program (MI)
- CIGNA and Dartmouth-Hitchcock Patient-Centered Medical Home Pilot (NH)
- NH Multi-Stakeholder Medical Home Pilot (NH)
- CDPHP Patient-Centered Medical Home Pilot (NY)
- EmblemHealth Medical Home High Value Network Project (NY)
- Hudson Valley P4P-Medical Home Project (NY)
- Greater Cincinnati Aligning Forces for Quality Medical Home Pilot (OH)
- Queen City Physicians/Humana Patient-Centered Medical Home (OH)
- TriHealth Physician Practices/Humana Patient-Centered Medical Home (OH)
- OU School of Community Medicine—Patient-Centered Medical Home Project (OK)
- Pennsylvania Chronic Care Initiative (PA)
- Rhode Island Chronic Care Sustainability Initiative (RI)
- Texas Medical Home Initiative (TX)
- Vermont Blueprint Integrated Pilot Program (VT)
- West Virginia Medical Home Pilot (WV)

Source: PCPCC Pilot Report (http://pcpcc.net/pilot-guide), October 2009

Blue Cross Blue Shield Plan Pilots (As of November 2010)

BlueCross BlueShield Association

An Association of Independent Blue Cross and Blue Shield Plans



Source: BCBS (www.bcbs.com)

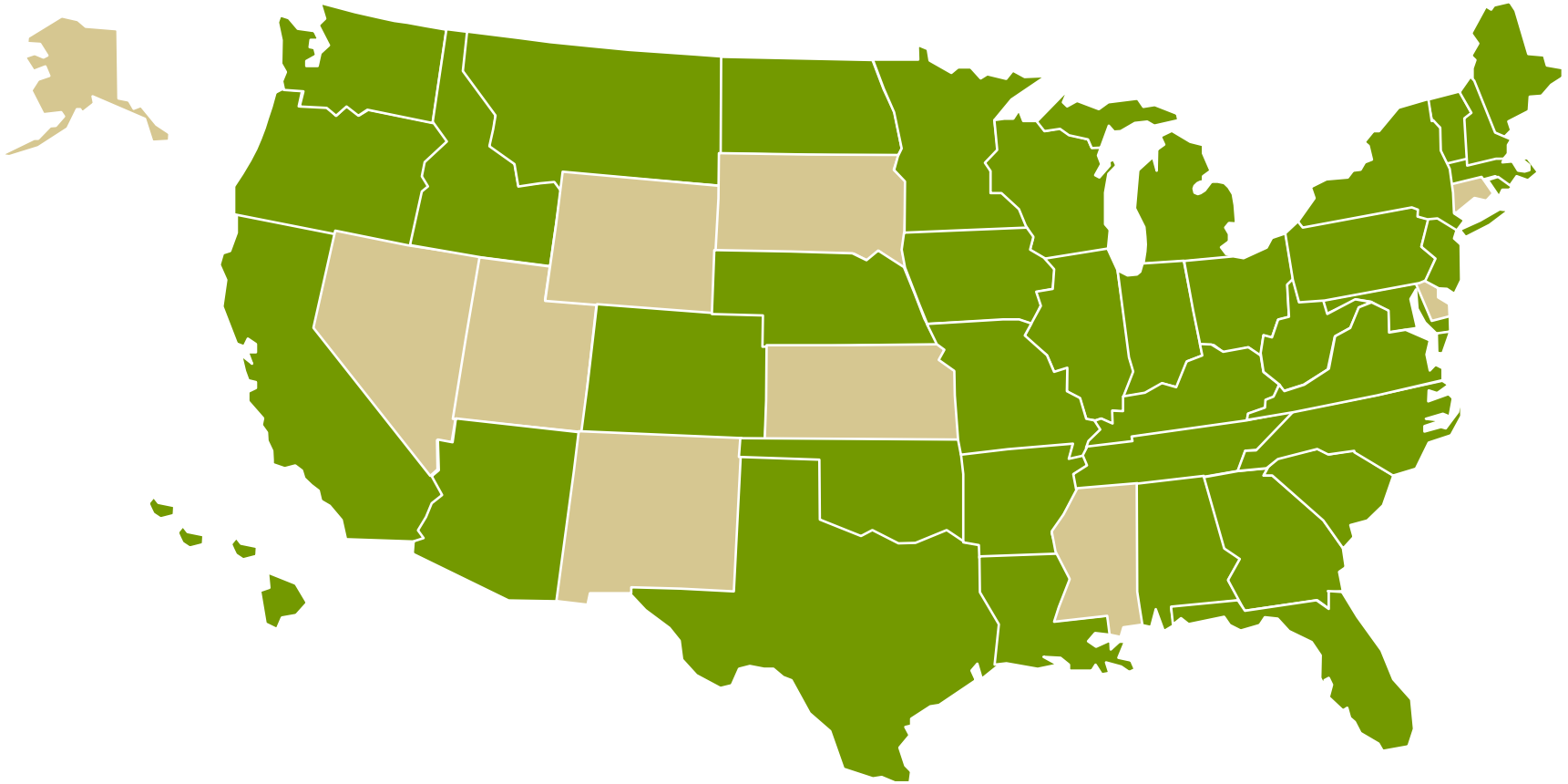
Overview of PCMH Commercial Pilot Activity

Additional commercial PCMH projects under development or underway in at least 21 more states:

- Arkansas
- California
- Hawaii
- Idaho
- Illinois
- Indiana
- Iowa
- Massachusetts
- Minnesota
- Missouri
- Montana
- Nebraska
- New Jersey
- North Carolina
- North Dakota
- Oregon
- South Carolina
- Tennessee
- Virginia
- Washington
- Wisconsin

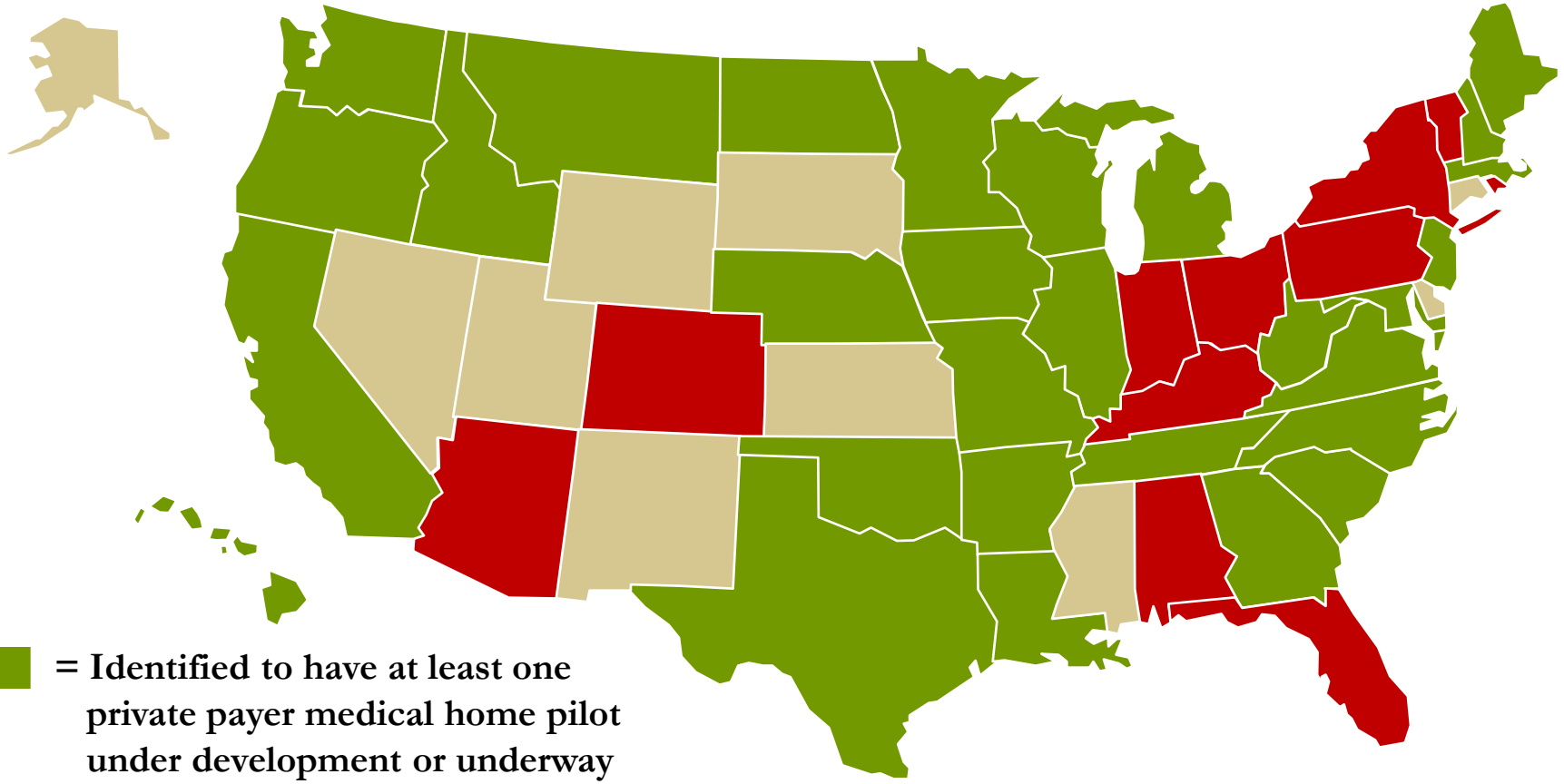
Additionally, new projects are under development in the previous states, such as New York (Adirondack region), Florida (BCBS)

Overview of PCMH Commercial Pilot Activity



= Identified to have at least one private payer medical home pilot under development or underway

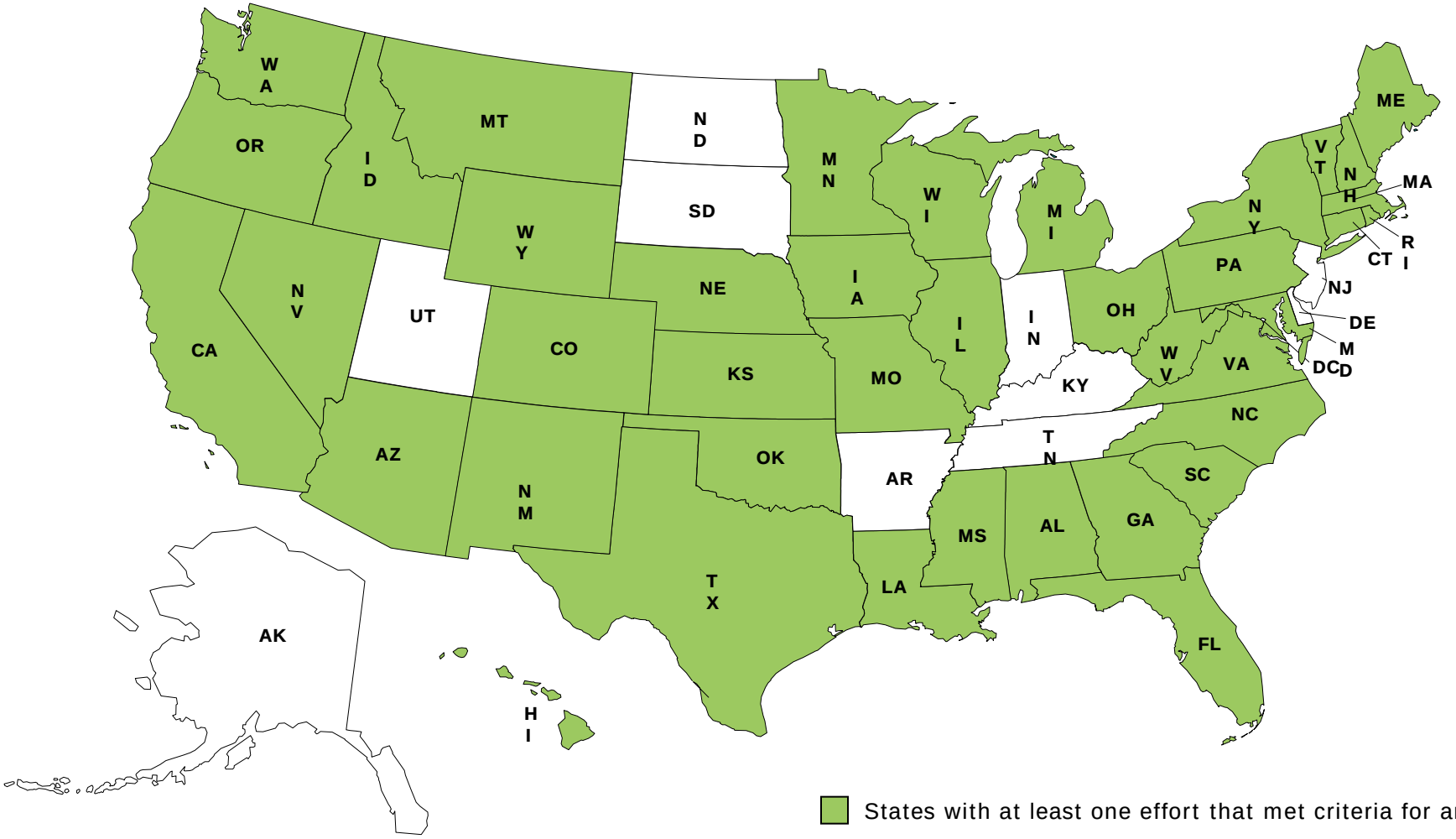
Overview of PCMH Commercial Pilot Activity - Medicare Advantage*



= Identified to have at least one private payer medical home pilot under development or underway

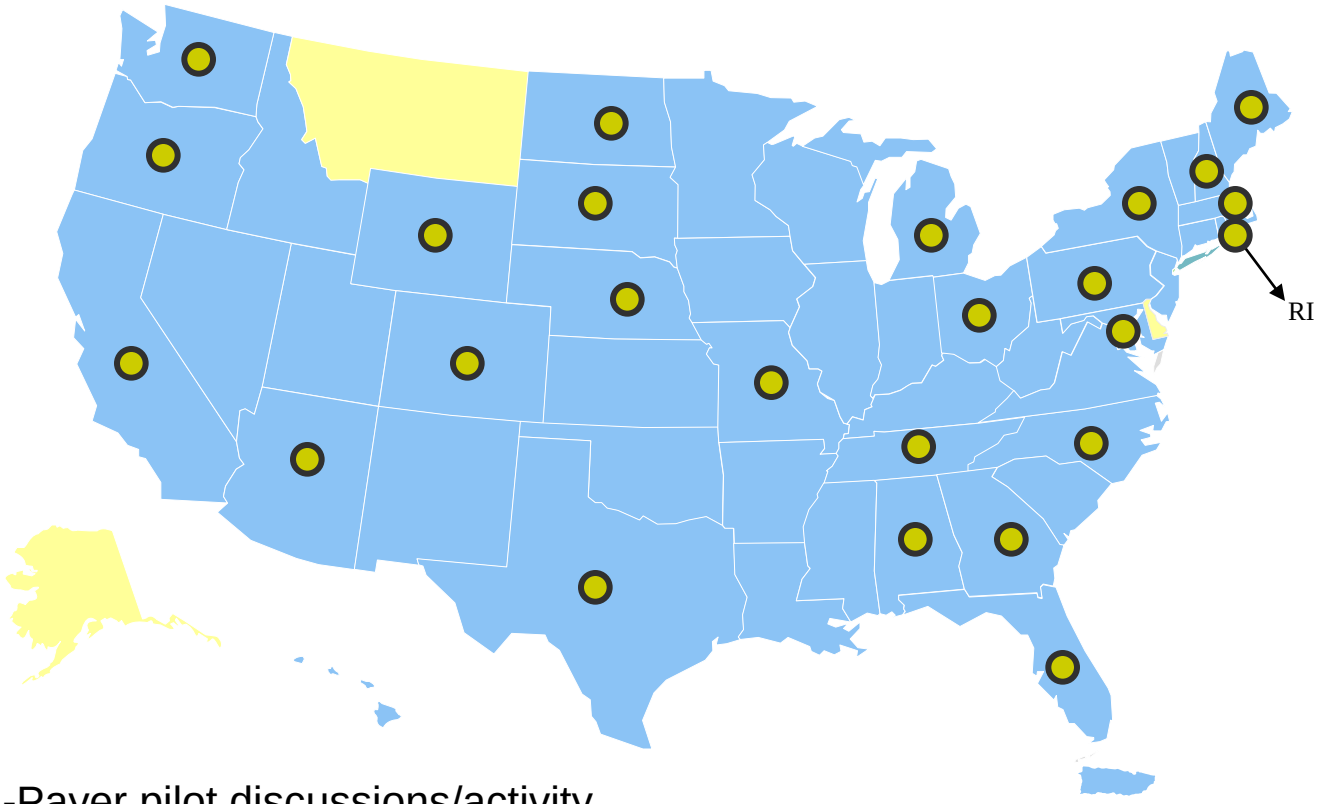
= Identified to have at least one private payer medical home pilot under development or underway that includes Medicare Advantage

There are 40 States Working to Advance Medical Homes for Medicaid or CHIP Beneficiaries



Patient-Centered Medical Home

Overview of Pilot Activity and Planning Discussions



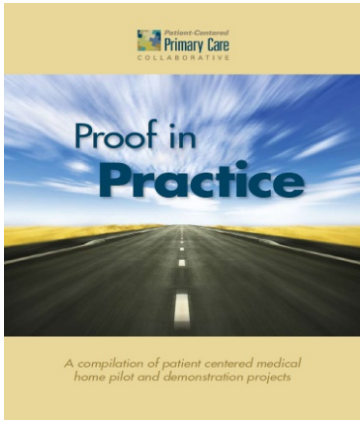
Multi-Payer pilot discussions/activity

Identified pilot activity

No identified pilot activity – 3 States

Source: PCPCC Pilot Report (http://pcpcc.net/pilot-guide), October 2009

More Results…



PCPCC Pilot Guide

And on the PCPCC website… www.pcpcc.net

PCPCC Membership and Activity Overview

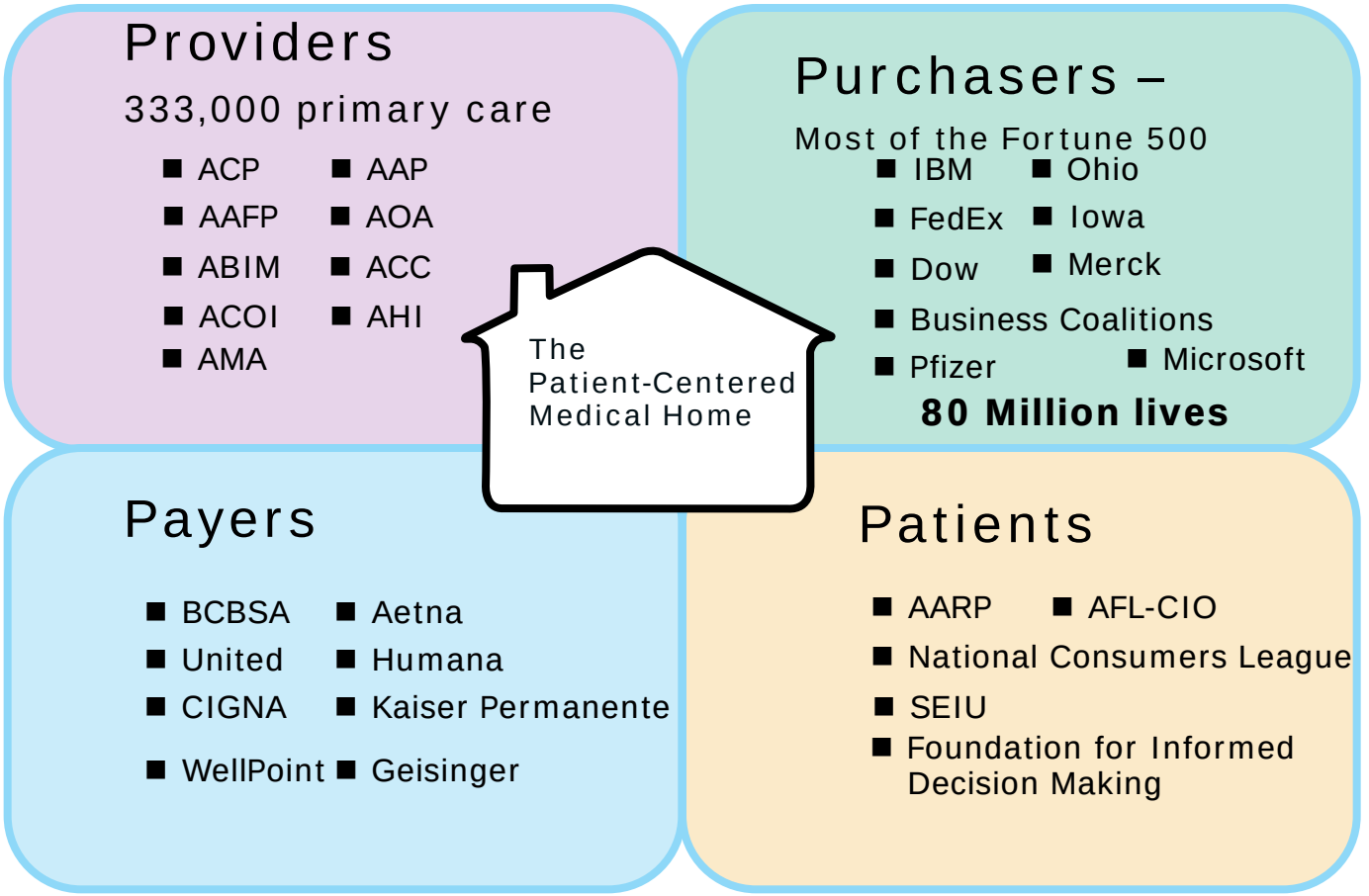
- National Convener on the PMCH and ACOS
- Legislative and Regulatory Advocacy
- Develop PCMH and ACO Policy

- More than public **750** members
- More than **3000** participants
- **62** Executive Committee Members
- **16** Advisory Board Members
- **6** Centers
- **9** Task Forces
- **2** Annual Conferences & Summits

- **Monthly Calls** (National PCMH Movement Briefings, CMD, CPPI, CCE, CEE, CeHIA)
- **National Weekly Call** (Thursday, 11AM EDT)
  - Phone number: 712.432.3900
  - Passcode: 471334
- Host Regular **Webinars**

The Patient-Centered Primary Care Collaborative

Examples of Broad Stakeholder Support & Participation



Source: PCPCC (www.pcpcc.net)

Patient Centered Primary Care Collaborative

Five 'Centers' - Over 770 volunteer members

Center for Multi-Stakeholder Demonstration: Identify community-based pilot sites in order to test and evaluate the concept; offer hands-on technical assistance, share best practices, and identify funding sources to advance adoption.

Center to Promote Public Payer Implementation: Assist state Medicaid agencies and other public payers as they implement and refine programs to embed the Patient Centered Medical Home model by offering technical assistance; sharing best practices and giving guidance on the development of successful funding models.

Center for Employer Engagement: Create standards and buying criteria to serve as a guide and tool for large and small employers/purchasers in order to build the market demand for adoption of the Medical Home model.

Center for eHealth Information Adoption and Exchange: Evaluate use and application of information technology to support and enable the development and broad adoption of information technology in private practice and among community practitioners.

Center for Consumer Engagement: Engage the consumer in awareness activities through three ways: day-to-day operations, messaging and pilots. The center will continue the use of "Patient Centered Medical Home", but focus on how the concept and its components are communicated to the public and partner with large consumer groups to capitalize on their visibility and existing efforts.

Source: PCPCC (www.pcpcc.net)

History of the Medical Home Concept

- The first known documentation of the term “medical home” Standards of Child Health Care, AAP in 1967 by the AAP Council on Pediatric Practice -- “medical home -- one central source of a child’s pediatric records” **History of the Medical Home Concept** Calvin Sia, Thomas F. Tonniges, Elizabeth Osterhus and Sharon Taba *Pediatrics* 2004;113;1473-1478
- Patient Centered – IOM
- I would strongly urge the adoption of the Danish model of the Patient Centered Medical Home -- Karen Davis Commonwealth Fund
- 2010 Medical Home Wikipedia page: http://en.wikipedia.org/wiki/Medical_home
- PCPCC Facebook Page

JOINT PRINCIPLES OF THE PCMH (FEBRUARY 2007)

The following principles were written and agreed upon by the four Primary Care Physician Organizations – the American Academy of Family Physicians, the American Academy of Pediatrics, the American College of Physicians, and the American Osteopathic Association.

Principles:

- Ongoing relationship with personal physician
- Physician directed medical practice
- Whole person orientation
- Coordinated care across the health system
- Quality and safety
- Enhanced access to care
- Payment recognizes the value added

Source: PCPCC (www.pcpcc.net)

ENDORSEMENTS

The PCMH Joint Principles have received endorsements from 18 specialty health care organizations:

- The American Academy of Chest Physicians
- The American Academy of Hospice and Palliative Medicine
- The American Academy of Neurology
- The American College of Cardiology
- The American College of Osteopathic Family Physicians
- The American College of Osteopathic Internists
- The American Geriatrics Society
- The American Medical Directors Association
- The American Society of Addiction Medicine
- The American Society of Clinical Oncology
- The Society for Adolescent Medicine
- The Society of Critical Care Medicine
- The Society of General Internal Medicine
- American Medical Association
- Association of Professors of Medicine
- Association of Program Directors in Internal Medicine
- Clerkship Directors in Internal Medicine
- Infectious Diseases Society of Medicine

Source: PCPCC (www.pcpcc.net)

Defining the Medical Home

Superb Access to Care

- Patients can easily make appointments and select the day and time.
- Waiting times are short.
- eMail and telephone consultations are offered.
- Off-hour service is available.

Patient Engagement in Care

- Patients have the option of being informed and engaged partners in their care.
- Practices provide information on treatment plans, preventative and follow-up care reminders, access to medical records, assistance with self-care, and counseling.

Clinical Information Systems

- These systems support high-quality care, practice-based learning, and quality improvement.
- Practices maintain patient registries; monitor adherence to treatment; have easy access to lab and test results; and receive reminders, decision support, and information on recommended treatments.

Care Coordination

- Specialist care is coordinated, and systems are in place to prevent errors that occur when multiple physicians are involved.
- Follow-up and support is provided.

Team Care

- Integrated and coordinated team care depends on a free flow of communication among physicians, nurses, case managers and other health professionals (including BH specialists).
- Duplication of tests and procedures is avoided.

Patient Feedback

- Patients routinely provide feedback to doctors; practices take advantage of low-cost, internet-based patient surveys to learn from patients and inform treatment plans.

Publically available information

- Patients have accurate, standardized information on physicians to help them choose a practice that will meet their needs.

PCMH as Foundation for Accountable Care Organizations

ACOs are defined as a group of providers that has the legal structure to receive and distribute incentive payments to participating providers.

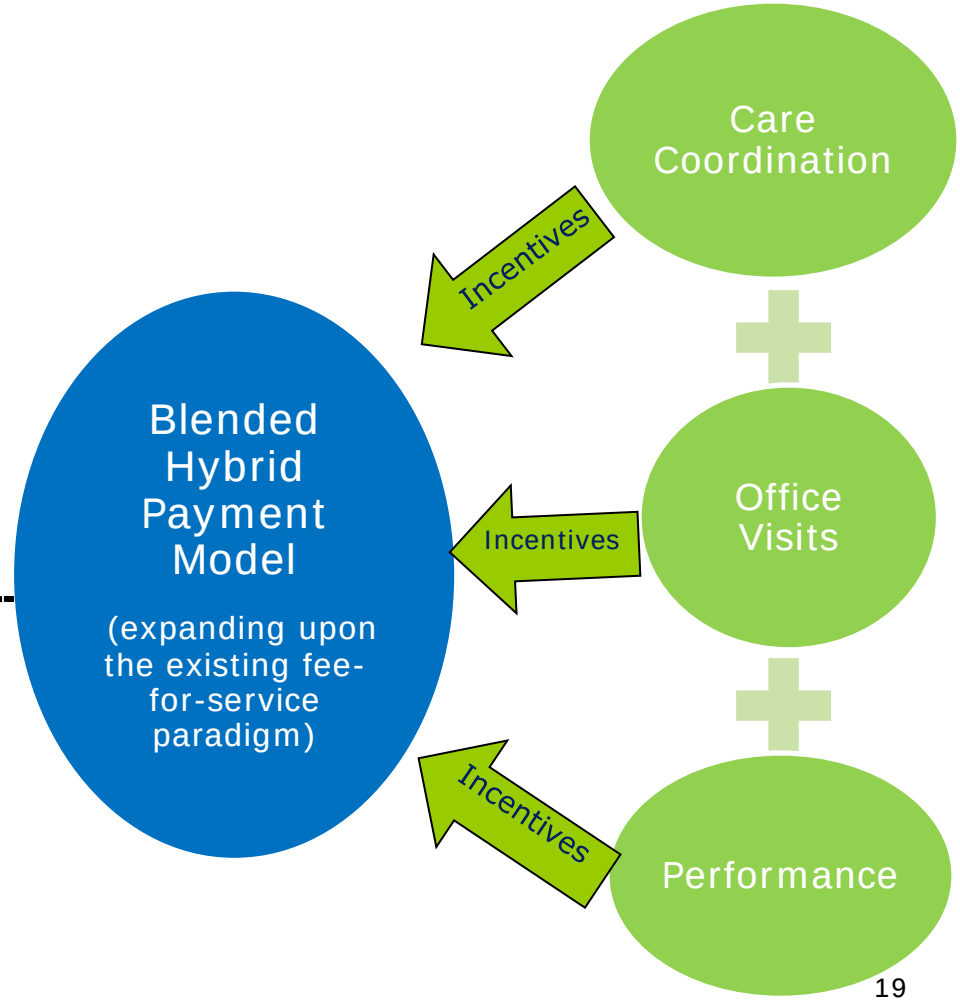
Source: Premier Healthcare Alliance

PCPCC Payment Model
May 2007

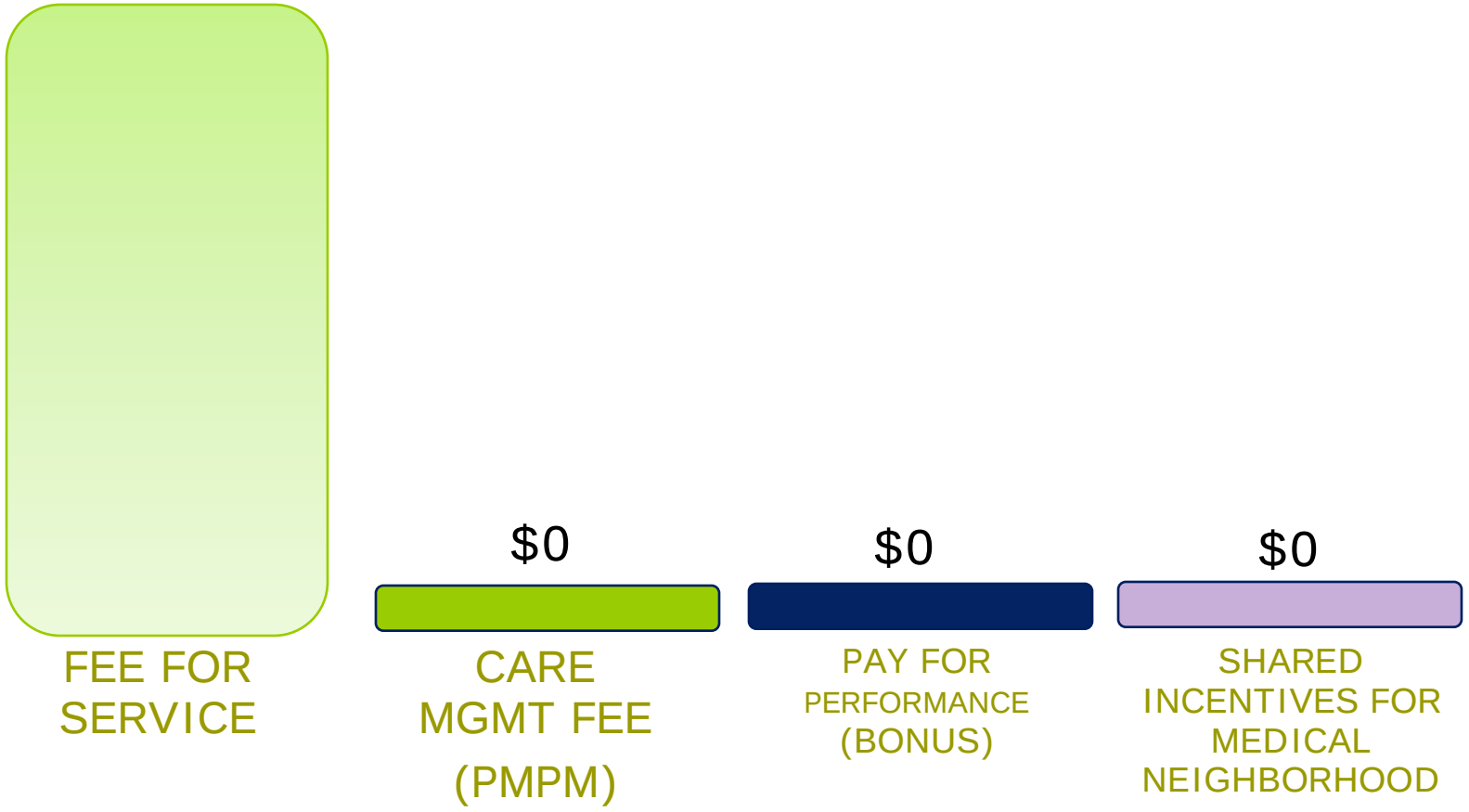
Key physician and practice accountabilities/ value added services and tools

- Proactively work to keep patients healthy and manage existing illness or conditions
- Coordinate patient care among an organized team of health care professionals
- Utilize systems at the practice level to achieve higher quality of care and better outcomes
- Focus on whole person care for their patients (including behavioral health)

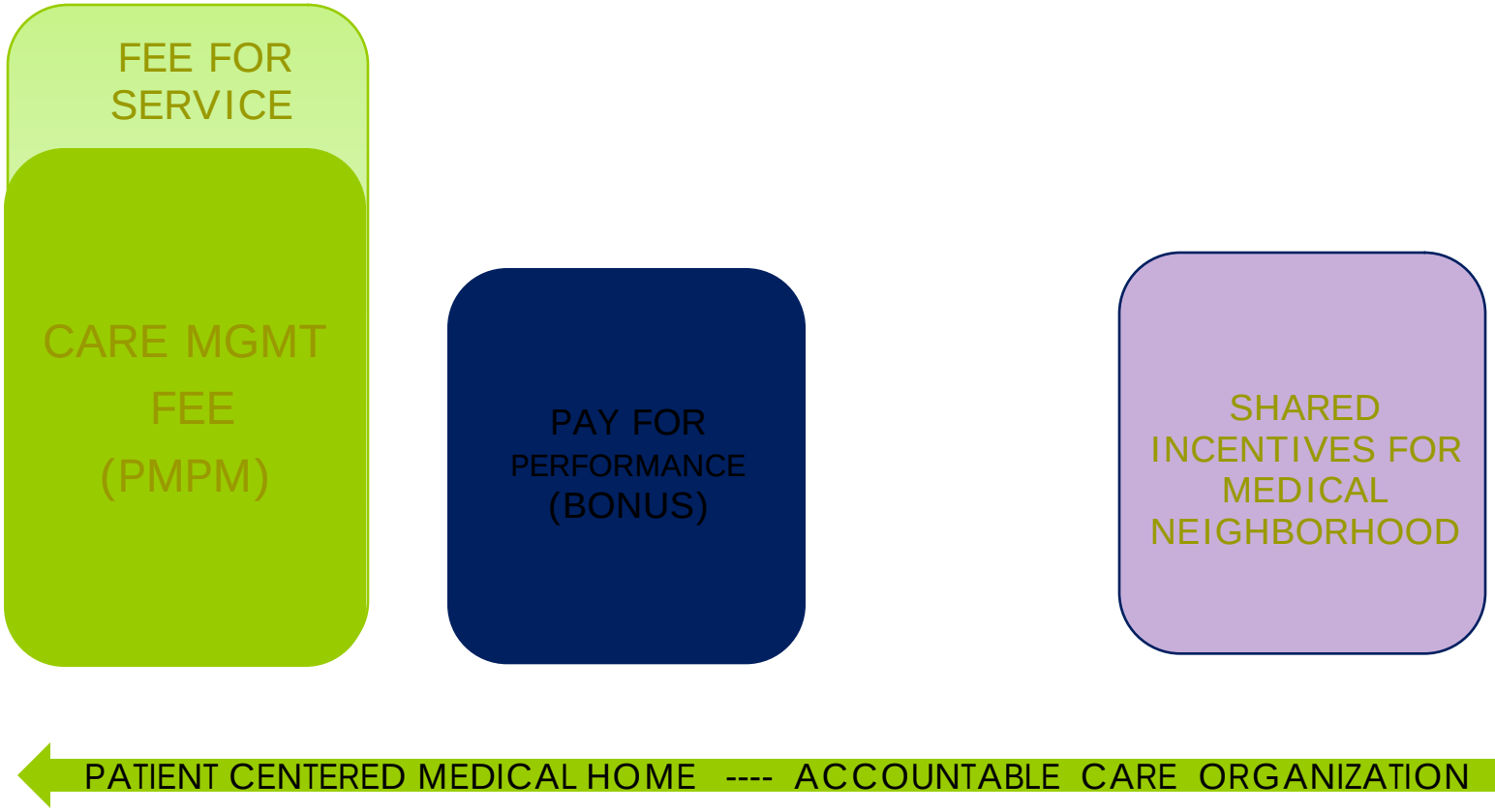
Performance Standards



CURRENT STATE



FUTURE STATE



Maryland Patient-Centered Medical Home Pilot

PMPM Payment: Commercial Population			
Physician Practice Size (# of patients)	Level of PCMH Recognition		
	Level 1+	Level 2+	Level 3+
< 10,000	$4.68	$5.34	$6.01
10,000 - 20,000	$3.90	$4.45	$5.01
> 20,000	$3.51	$4.01	$4.51

Minnesota Health Care Homes

Tier	Major Condition Groups	Minutes of Work PMPM	PMPM Payment
0	None	N/A	N/A
1	3-Jan	15	$10.14
2	6-Apr	30	$20.27
3	9-Jul	60	$40.54
4	10+	90	$60.81

New York: Capital District Physicians' Health Plan

Payment Model Component	PMPM Payment
Practice transformation cost payments (year 1 only)	$1.67 PMPM
Performance bonus (beginning in year 2)	Up to $2.38 PMPM (value based on performance)
Risk-adjustment	Up to $1.67 PMPM (only for practices with above average patient panel risk profiles; amount varies by practice)

New York: EmblemHealth Medical Home High Value Network Project

Payment Model Component	PMPM Payment
Care management payments	Up to $2.50 PMPM
Pay-for-performance payments	Up to $2.50 PMPM

Pennsylvania Chronic Care Initiative

Payment Model Component	PMPM Payment
Practice support payments	$1.50 PMPM
Care management payments	$0.60 PMPM (ages 0-17)
	$1.50 PMPM (ages 18-64)
	$5.00 PMPM (ages 65-74)
	$7.00 PMPM (ages 75+)
Shared savings	Value based on performance

EVIDENCE OF COST SAVINGS & QUALITY IMPROVEMENT

Barbara Starfield of Johns Hopkins University

- Within the United States, **adults with a primary care physician rather than a specialist had 33 percent lower costs of care and were 19 percent less likely to die**.
- In both England and the United States, **each additional primary care physician per 10,000 persons is associated with a decrease in mortality rate** of 3 to 10 percent.
- In the United States, **an increase of just one primary care physician is associated with 1.44 fewer deaths per 10,000 persons.**

Commonwealth Fund has reported:

- A medical home can reduce or even eliminate racial and ethnic disparities in access and quality for insured persons.

Denmark has organized its entire health care system around patient-centered medical homes, achieving the highest patient satisfaction ratings in the world. Denmark has among the lowest per capita health expenditures and highest primary care rankings.

Investing in Primary Care Patient Centered Medical Homes, results in:

- Improved quality of care,
- Higher patient satisfaction,
- Savings in Hospital and Emergency room utilization.

Source: PCPCC (www.pcpcc.net)

Community Implications - Published Results of PCMH Projects to Date

Group Health Cooperative of Puget Sound

- 29% reduction in ER visits
- 16% reduction in hospital admissions
- Reduced cost

Geisinger Health System

- 18% decrease in hospital admissions
- Improvements in diabetes and heart disease care
- 7% reduction in costs

Source: PCPCC Pilot Guide, 2010

Community Implications – Published Results of PCMH Projects (cont.)

Veterans Health Administration

- Improved Chronic Disease treatments
- 27% reduction in ER visits & hospitalizations
- Lower median costs for veterans with chronic conditions ($4,491 versus $5,084)

HealthPartners Medical Group MN

- 39% decrease in ER visits
- 24% decrease in hospital admissions
- Enrollment cost reduced to 92% of the state average

Source: PCPCC Pilot Guide, 2010

Community Implications – Published Results of PCMH Projects (cont.)

Intermountain Healthcare Medical Group Care Management Plus

- 39% Decrease in emergency room admissions
- 24% Decrease in hospital admissions
- Net reduction cost of 640$ per patient and 1,650$ among high risk patients

BlueCross BlueShield of NC-Palmetto Primary Care Physician

- 12.4% decrease in ER visits
- 10% decrease in hospital admissions
- Total medical and pharmacy costs were 6.5% lower

Source: PCPCC Pilot Guide, 2010

Community Implications – Published Results of PCMH Projects (cont.)

Medicaid Sponsored PCMH initiatives

- North Carolina: $974.5 Million cumulative savings over 6 years and 16% lower ER visits
- Colorado: PCMH Children's annual median cost was $2,275 compared to those not enrolled $3,404

Miscellaneous PCMH Programs

- John Hopkins: 24% Reduction in total Inpatient days
- Genesee MI:50% Reduction in ER visits
- Erie County: Organizational savings of 1$ million per 1000 enrollees

Source: PCPCC Pilot Guide, 2010

Simple Cost Avoidance

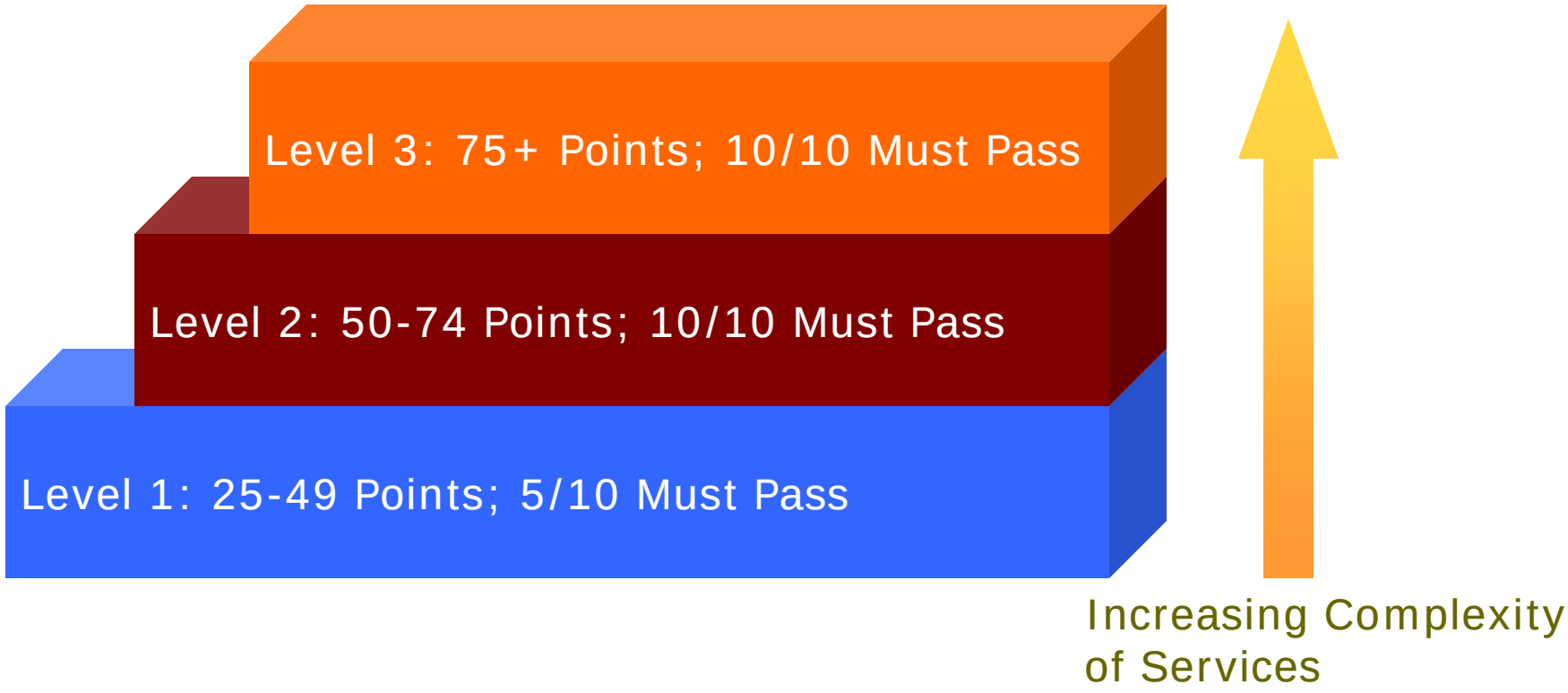
NC Savings (FY04)

Category of Service	Estimated Savings from Benchmark
Inpatient	$142,085,680
Outpatient	$51,865,028
Emergency Room	$25,944,553
Primary Care, Specialist	$45,498,709
Pharmacy	$(15,526,996)
Other	$(5,065,238)
Totals	**$244,801,735**

Source: PCPCC (www.pcpcc.net)

Recognition Programs for PCMH Developed or Under Development

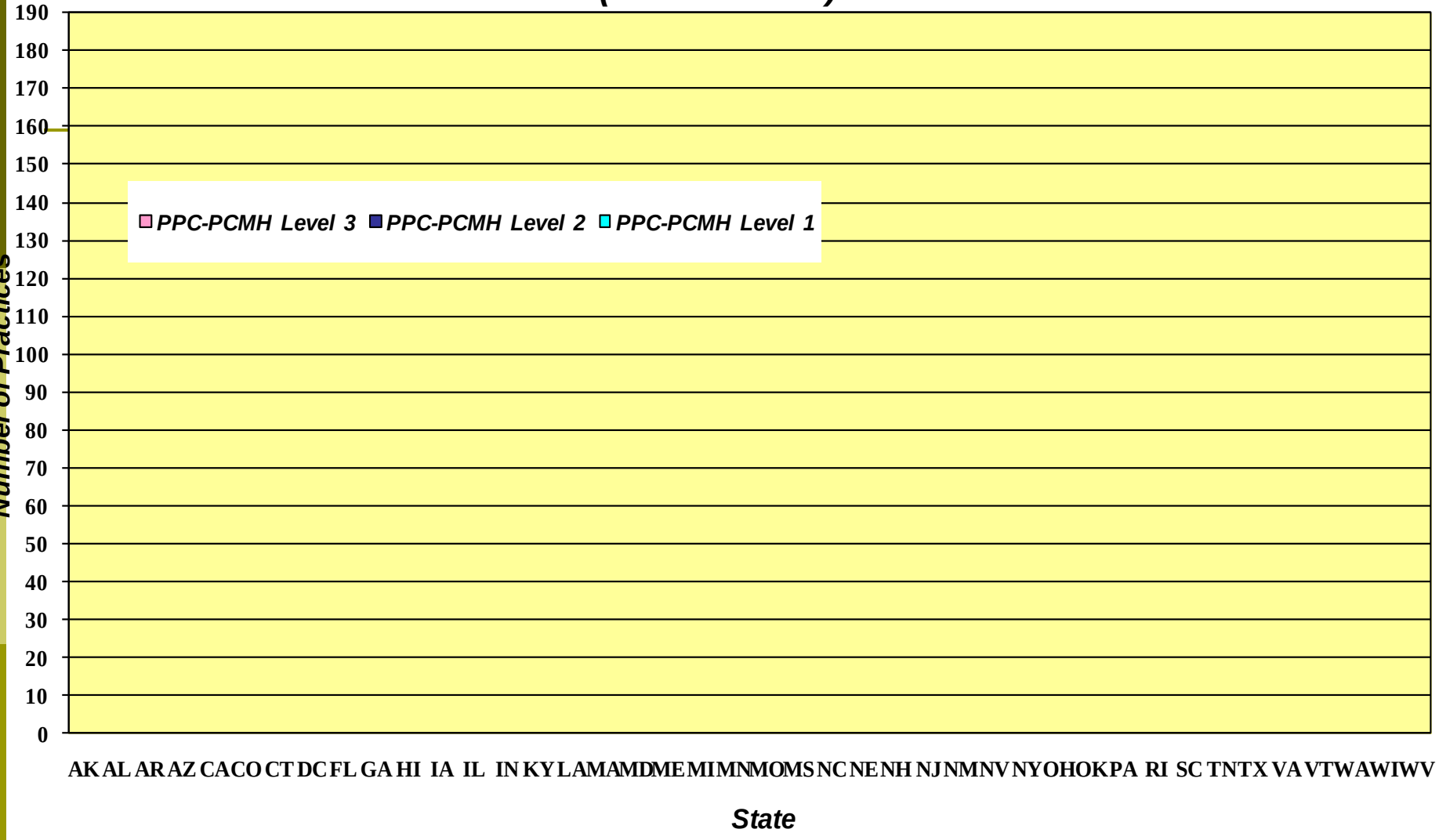
NCQA
Scoring: Building a Ladder to Excellence



Source: NCQA(www.ncqa.org)

PPC-PCMH RECOGNIZED PRACTICES BY STATE

(As of 9/30/10)



Federal PCMH Efforts

Veterans Administration

- 820 primary care sites
- 4.5 million primary care patients

Department of Defense

- National Naval Medical Center PCMH Pilot
- Tri-Service Medical Home Summit
- "The PCMH model of care will be implemented across the Services" – MHS Policy Statement on September 18, 2009

PCMH Activities also occurring in: AHRQ, SAMHSA, CDC

Source: PCPCC (www.pcpcc.net)

Federal PCMH Efforts: Medicare FFS

Medicare "Advanced Primary Care" Demonstration Project

On November 16th 2010, ME, VT, RI, NY, PA, NC, MN, MI announced their participation in the Multi-payer Advancement Primary Care Practice Demonstration, giving them the opportunity to assess the effect of advanced primary care practice, and are supported by Medicare, Medicaid, and private health plans.

Center for Medicare & Medicaid Service

- **CMS announced the creation of the Innovation Center which will examine new payment methods and healthcare delivery models that emphasize primary care. The Innovation Center will focus on these new models of care, such as the patient centered medical home and accountable care organizations to test their impact on both quality and success of new payment models.**

For more information on CMS/Medicare PCMH Efforts:
http://www.acponline.org/running_practice/pcmh/demonstrations/index.html

Encouraging Movement
White House, Senate and House

Major provisions of the Health Care Reform bills relevant to Primary Care and PCMH

Workforce Supply and Training

- **Obama Administration and HHS Announce New $250 Million Investment to Strengthen Primary Health Care Workforce Through: (1)** Creating additional primary care residency slots; **(2)** Supporting physician assistant training in primary care; **(3)** Encouraging students to pursue full-time nursing careers; **(4)** Establishing new nurse practitioner-led clinics; and **(5)** Encouraging states to plan for and address health professional workforce needs

Medicaid and Medicare Pilots

- **Section 2703 of the Patient Protection and Affordable Care Act creates a new Medicaid state plan option to cover medical homes,** beginning January 1, 2011, under which certain Medicaid enrollees with chronic conditions could designate a health home, as defined by the Secretary. States that choose to offer this benefit option, will be reimbursed for payments by the federal government 90% for the first eight fiscal quarters.
- **Establishment of Center for Medicare and Medicaid Innovation within CMS**. The purpose of the Center will be to research, develop, test, and expand innovative payment and delivery arrangements to improve the quality and reduce the cost of care provided to patients in each program.

Payment Reform

- **Payments to primary care physicians.** Requires that Medicaid payment rates to primary care physicians for furnishing primary care services be no less than 100% of Medicare payment rates in 2013 and 2014.
- **Expanding access to primary care services and general surgery services.** Beginning in 2011, provides primary care practitioners, as well as general surgeons practicing in health professional shortage areas, with a 10 percent Medicare payment bonus for five years

PCPCC Resources

Value-Based Insurance Design

IT Guide

Purchaser Guide

Payment Reform Guide

Clinical Decision Support Guide

Pilot Guide

Consumer Guide

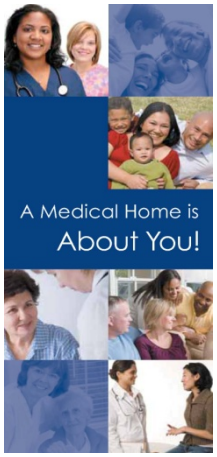
Medication Management Guide

Participatory Engagement Guide

PCMH – Evidence of Quality

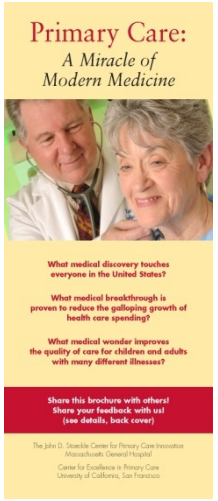
Source: PCPCC (www.pcpcc.net)

Information Flow- Consumer Materials



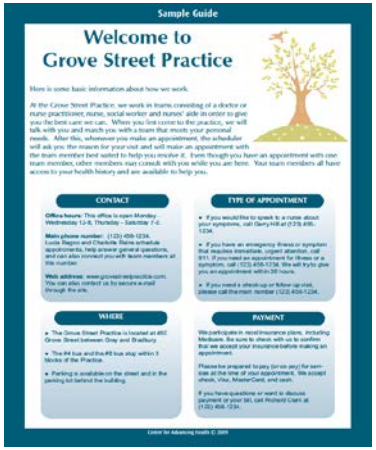
What consumers can expect- PCMH consumer principles (brochure)

Four minute video for waiting room viewing; deep-dive on PCMH (Flash)



Promotes Primary Care (brochure)

Deep-dive focus on PCMH (brochure)



Guidance to create your own practice brochure in support of PCMH model (paper)

Source: PCPCC (www.pcpcc.net)

Test Drive the New PCPCC Website !

- Major features include
  - Master calendar listing all PCPCC events
  - On-line and interactive Pilot Guide
  - User portals (consumer & patients, employer & health plans, providers & clinicians, federal & state government
  - Center portals and updates

http://www.pcpcc.net

UPCOMING COLLABORATIVE EVENTS

Wednesday, March 30, 2011 - Washington D.C., Stakeholder Meeting - Ronald Reagan Building and International Trade Center

Thursday, October 21, 2011 - Washington D.C., Annual Summit - Ronald Reagan Building and International Trade Center

CONTACT INFORMATION

Visit our website – http://www.pcpcc.net

To request any additional information on the PCMH or the Patient Centered Primary Care Collaborative please contact:

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