



Patient Centered Primary Care Collaborative and the National Patient Centered Medical Home Movement

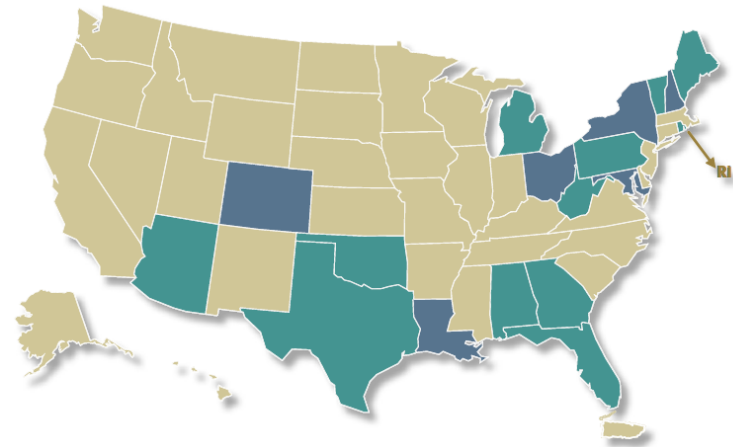
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Overview of Activity

- 27 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)

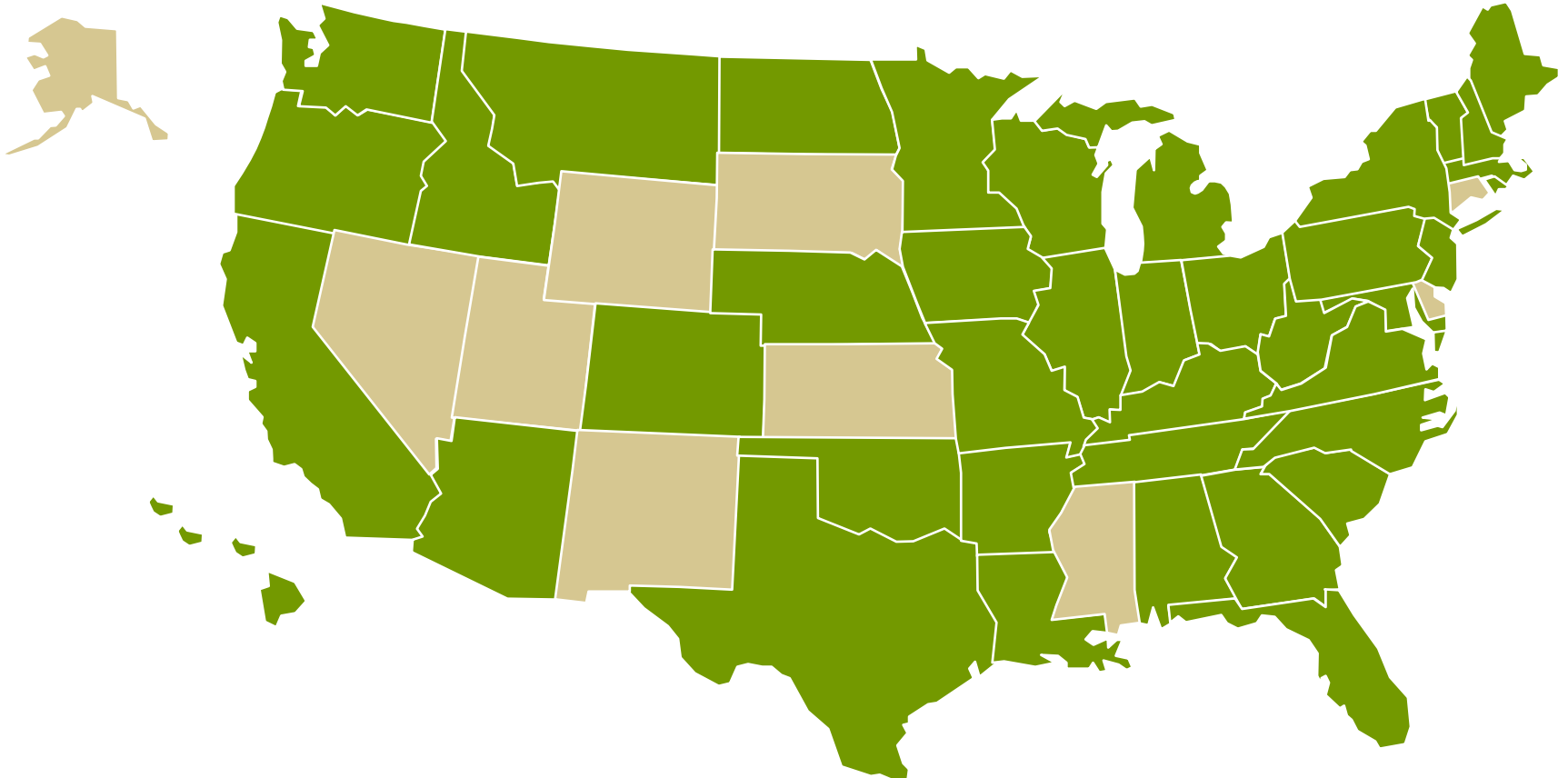
Overview of PCMH Commercial Pilot Activity


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

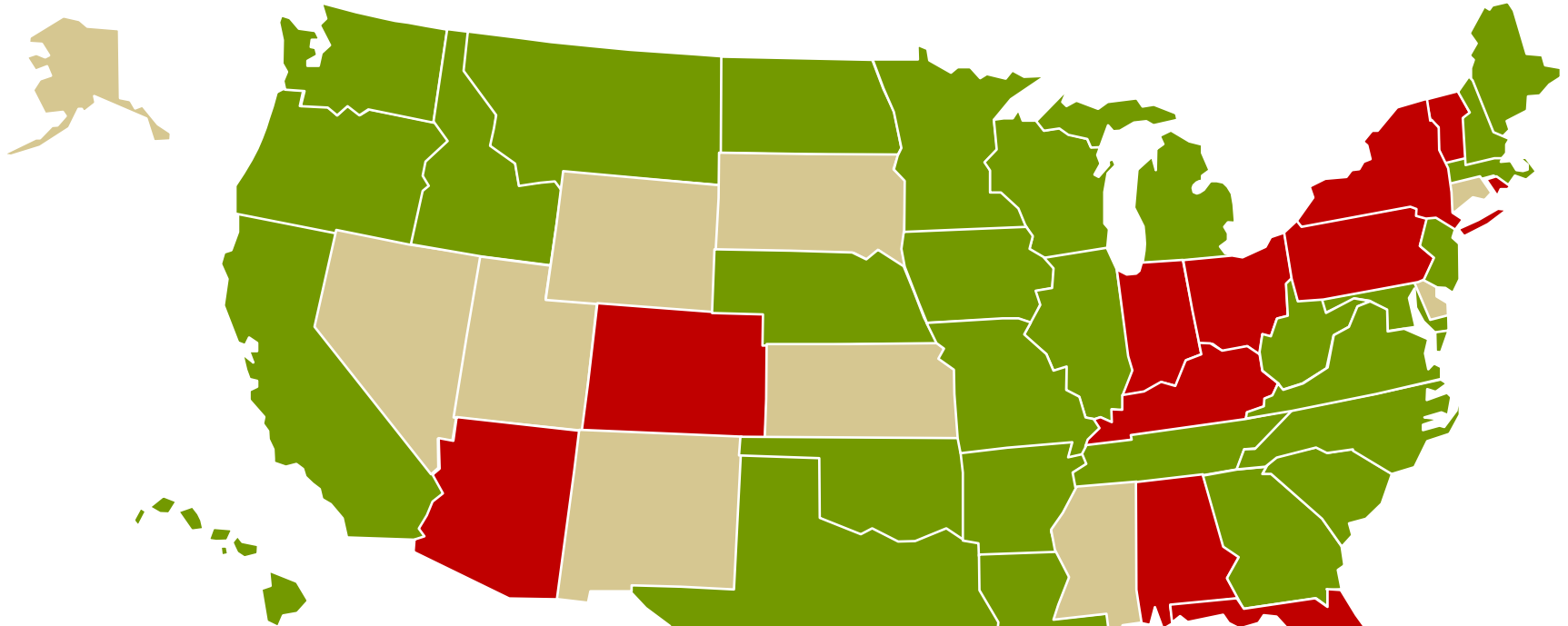
Additionally, new projects are under development in the previous states, such as New York (Adirondack region), Florida (BCBS)



Overview of PCMH Commercial Pilot Activity



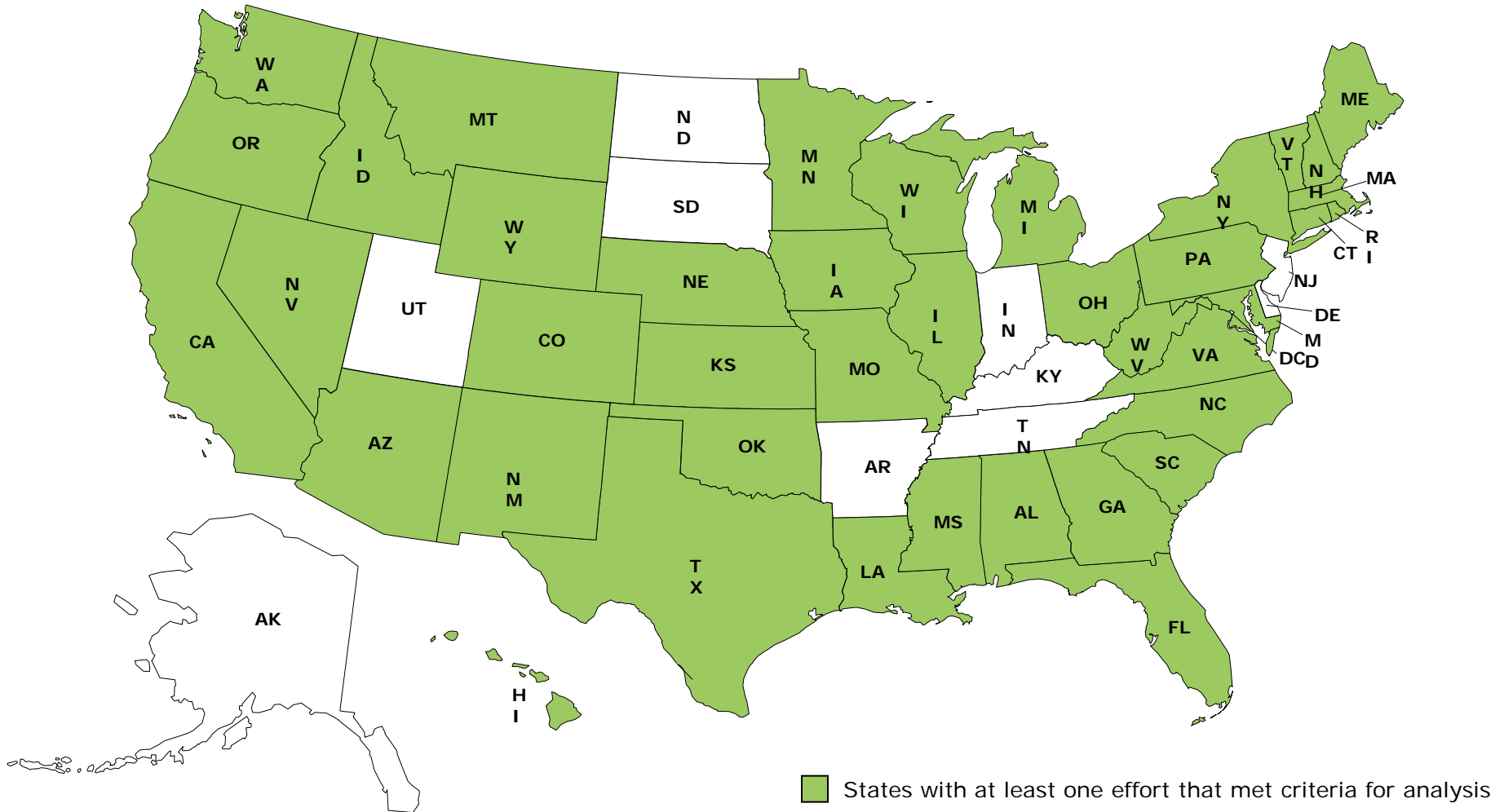
 = Identified to have at least one private payer medical home pilot under development or underway

Overview of PCMH Commercial Pilot Activity - Medicare Advantage*

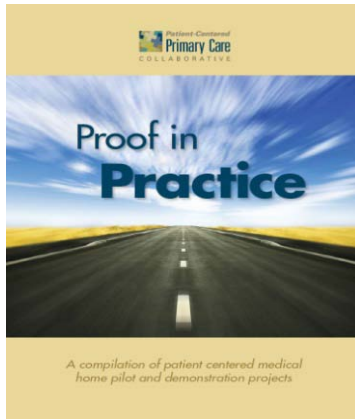


-  = Identified to have at least one private payer medical home pilot under development or underway
-  = Identified to have at least one private payer medical home pilot under development or underway that includes Medicare Advantage

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



More Results...



PCPCC Pilot Guide

And on the
PCPCC website...
www.pcpcc.net



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CMD

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CMD Topics

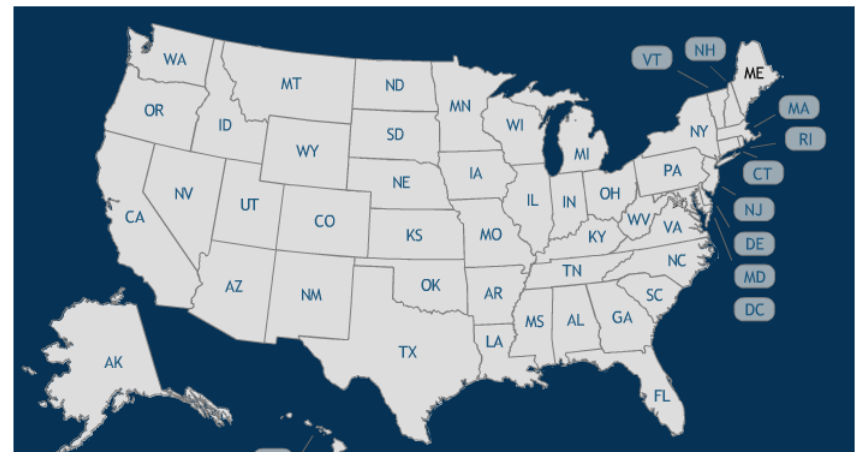
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Center for Multi-Stakeholder Demonstrations

The primary objective of the Center for Multi-Stakeholder Demonstrations (CMD) is to serve as a dissemination center for information on patient centered medical home (PCMH) pilot efforts around the country that include multiple stakeholders, such as private and public payers, purchasers, providers, and patients. The CMD assists these stakeholders, as well as local and regional convening entities, with their demonstration efforts through sharing of best practices, lessons learned, and results from existing PCMH projects. This is accomplished by the CMD serving as an information exchange where stakeholders can share and discuss innovative approaches.



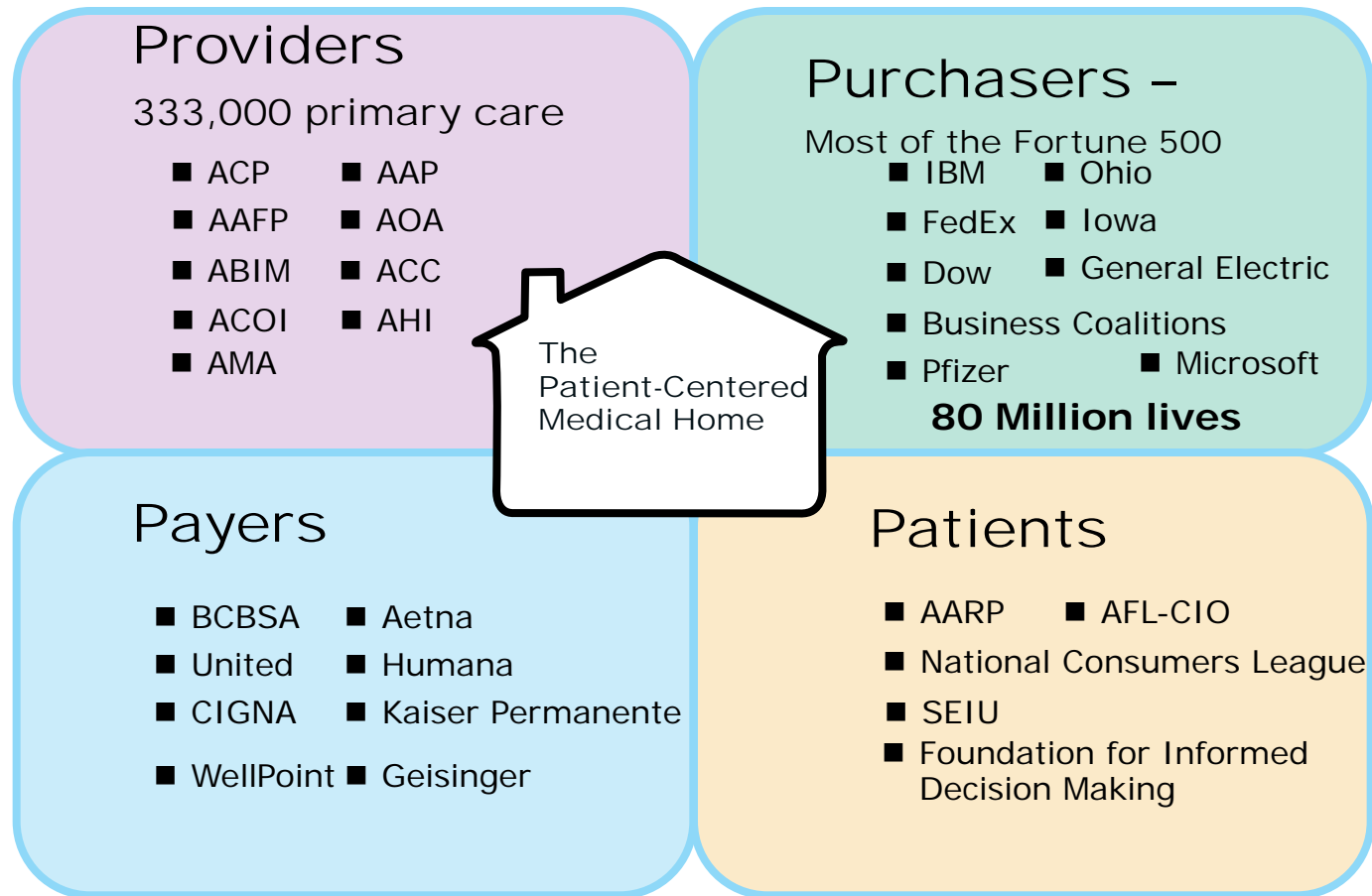
PCPCC Membership and Activity Overview

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

- More than **750** members
- **62** Executive Committee Members
- **16** Advisory Board Members
- **5** 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



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.

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:

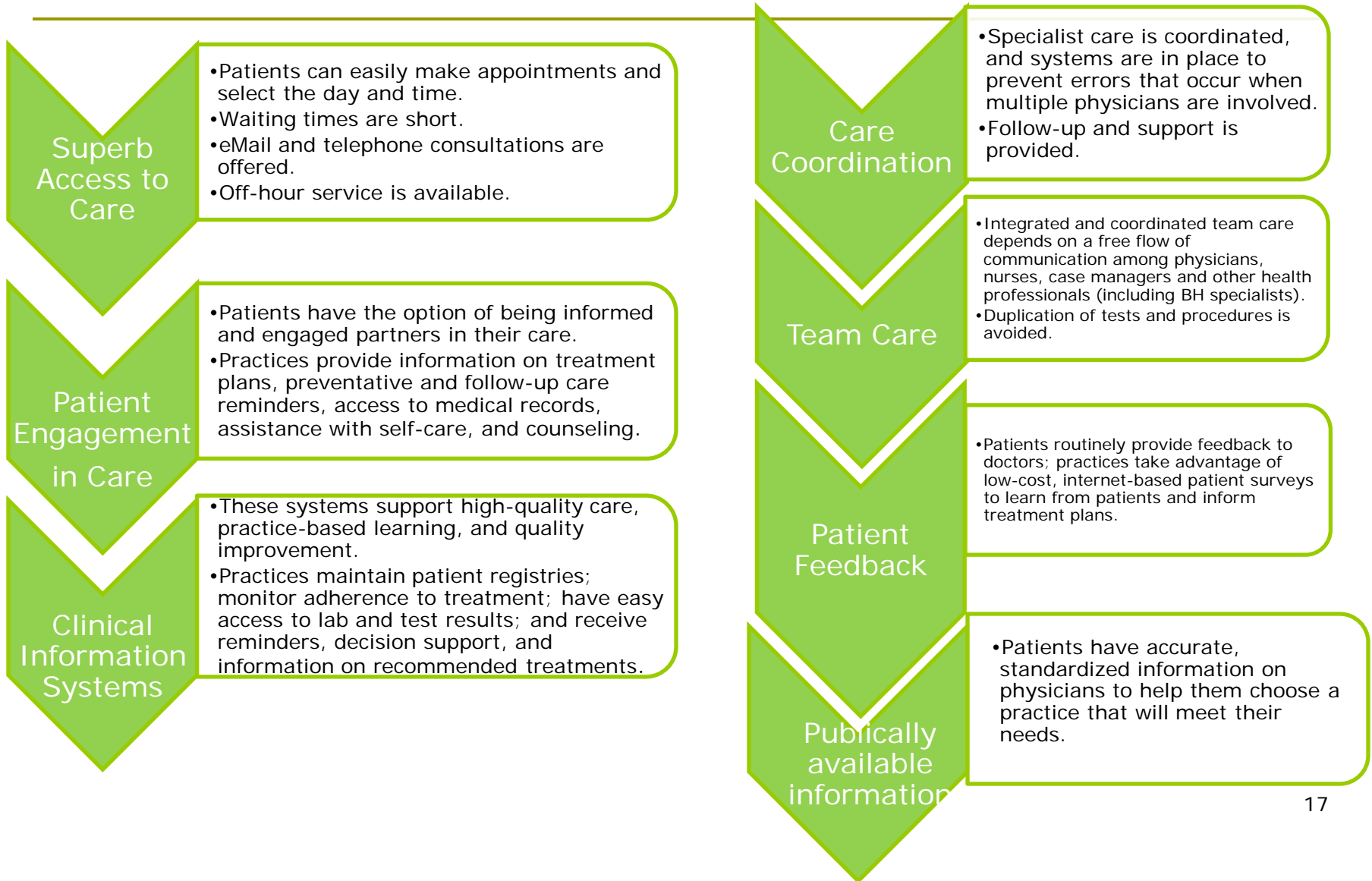
- Ongoing relationship with personal physician
- Physician directed medical practice
- Whole person orientation
- Coordinated care across the health system
- Quality and safety
- Enhanced access to care
- Payment recognizes the value added

ENDORSEMENTS

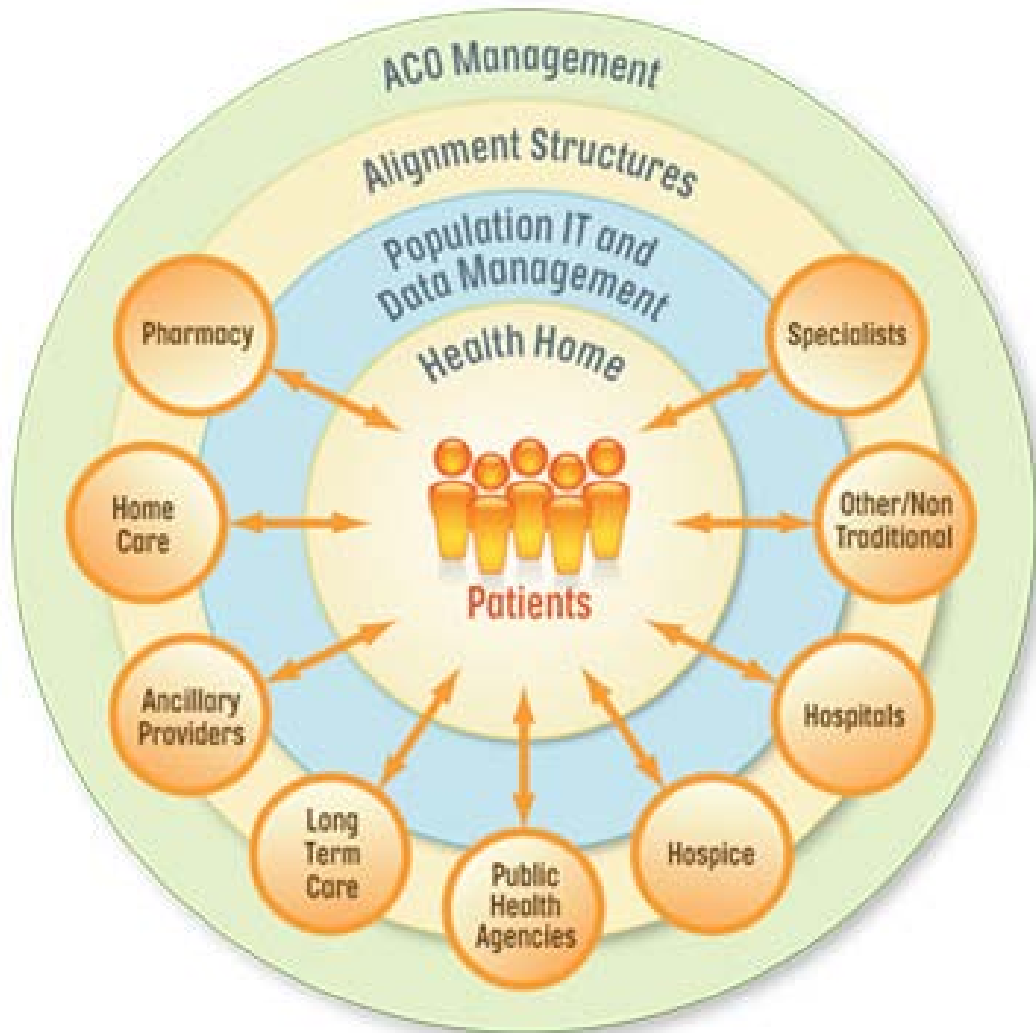
The PCMH Joint Principles have received endorsements from 18 specialty health care organizations:

- 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

Defining the Medical Home



Accountable Care Organizations (ACO)

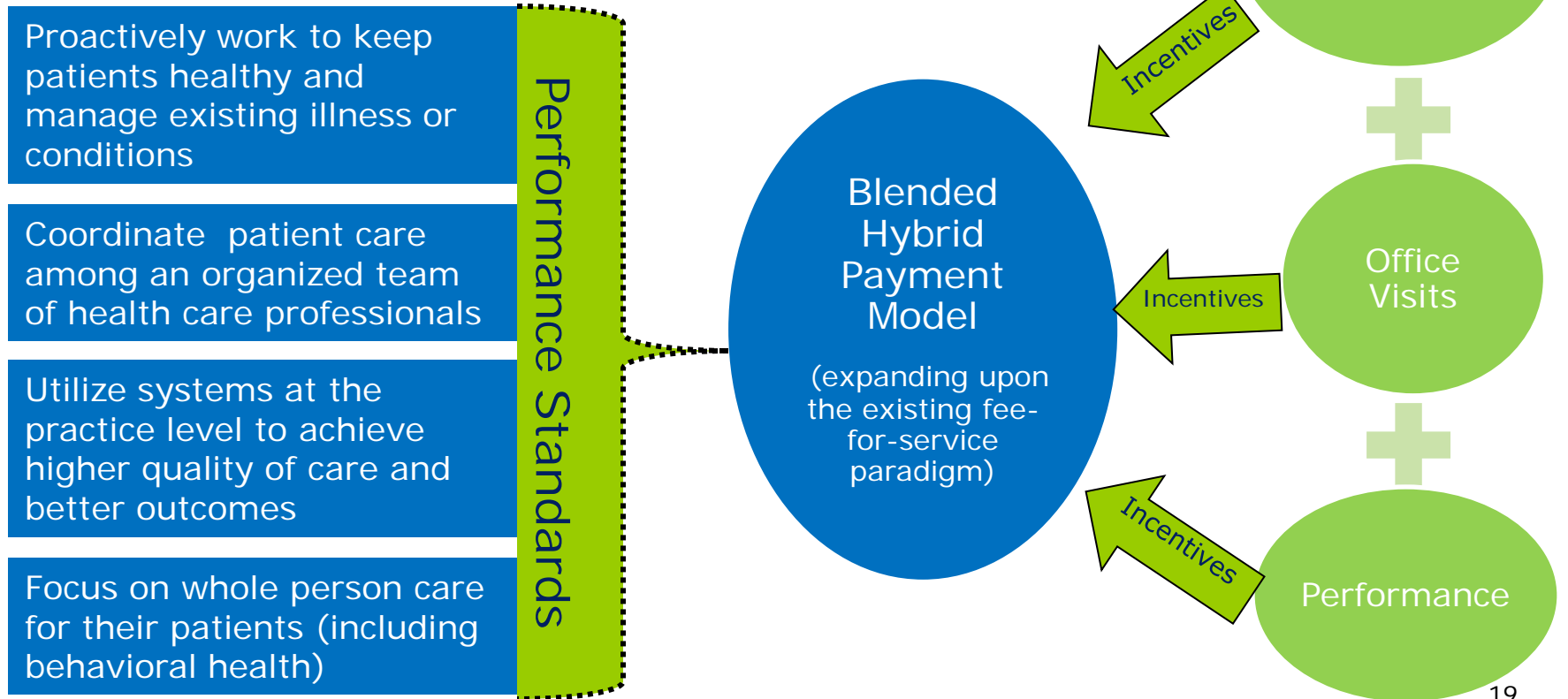


ACOs are defined as a group of providers that has the legal structure to receive and distribute incentive payments to participating providers.

PCPCC Payment Model

May 2007

*Key physician and practice
accountabilities/ value added
services and tools*



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.

Center for Evaluative Clinical Sciences at Dartmouth, states in the US relying more on primary care have:

- lower Medicare spending,
- lower resource inputs,
- lower utilization, and
- better quality of care.

Community Implications - Published Results of PCMH Projects to Date

Group Health Cooperative of Puget Sound

- 29% reduction in ER visits; 11% reduction in ambulatory care sensitive admissions
- Improvements in diabetes and heart disease care
- Cost neutral after 1 year

Geisinger Health System

- 14% decrease in hospital admissions
- Improvements in diabetes and heart disease care
- 9 % reduction in costs
- ROI greater than 2 to 1

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

Colorado Medicaid & SCHIP

- Median annual costs \$785 vs \$1000
- Reduction in ER visits & hospitalizations
- More well-child visits (72% vs 27%)
- Lower median costs for children with chronic conditions (\$2,275 versus \$3,404)

HealthPartners Medical Group (MN)

- 39% decrease in ER visits
- 24% decrease in hospital admissions
- Better diabetes and cardiac care
- Reduced costs

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

Metcare of Florida/Humana PCMH Program

- Started in November 2008 & Concluded in October 2009
- Studied the impact of the PCMH model in a Medicare Advantage (MA) capitated group
- Hospital days per 1000 customers dropped by 4.6 percent compared to an increase of 36 percent in the control group
- Hospital admissions per 1000 customers dropped by three percent, with readmissions running six percent below Medicare benchmarks
- Emergency room expense rose by only 4.5% for the Metcare group compared to an increase of 17.4% for the control group
- Overall medical expense for the Metcare group rose by only 5.2 percent compared to 26.3 percent increase for the control group
- Preventive breast and colorectal cancer screening was 13.3 percent and 6.3 percent higher respectively, compared to the control group
- Average LDL cholesterol levels dropped by 1.8 percent, and customers with levels below 100 (a target level) rose by 4.0 percent
- Ninety-four percent of diabetic patients had an A1C level of less than nine percent

Community Implications – Preliminary Findings of Other PCMH Projects (cont.)

National Naval Medical Center Medical Home Program (Bethesda, MD)

- Started 4/1/08 – ongoing
- 1 IM practice; 35,000 covered lives
- PCM continuity of care increase of 33%
- 20.8% decrease in network ER visits per 100 enrollees
- 39.5% decrease in total annual ER visits per 100 enrollees
- 40.4% decrease in total specialty care visits per 100 enrollees

Community Implications – Preliminary Findings of Other PCMH Projects (cont.)

Rhode Island Chronic Care Sustainability Initiative

- Started 10/1/08; 2-3 years
- 5 IM and FP practices; 28,000 covered lives
- Multi-stakeholder
- First nine months of program (all sites combined):
 - Diabetes patients with a documented hemoglobin A1c improved from 64% to 72%
 - Diabetes patients with BP <130/80 improved from 18% to 30%
 - CAD patients on Beta blocker improved from 40% to 65%
 - Smokers with documented advice to quit improved from 14% to 35%

Simple Cost Avoidance

NC Savings (FY04)

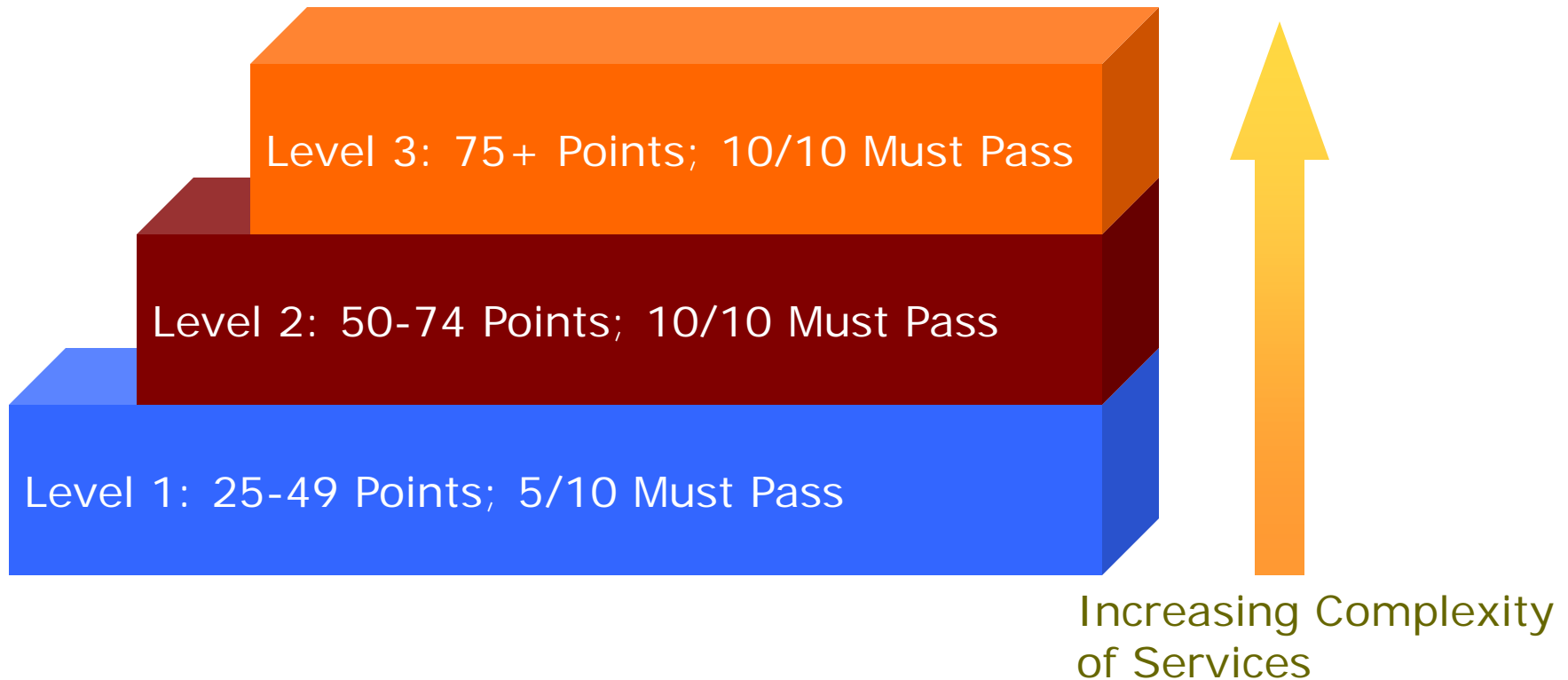
Category of Service	Estimated Savings from Benchmark
Inpatient	\$142,085,680
Outpatient	\$51,865,028
Emergency Room	\$25,944,553
Primary Care, Specialist	\$45,498,709
Pharmacy	\$(15,526,996)
Other	\$(5,065,238)
Totals	\$244,801,735

Recognition Programs for PCMH Developed or Under Development

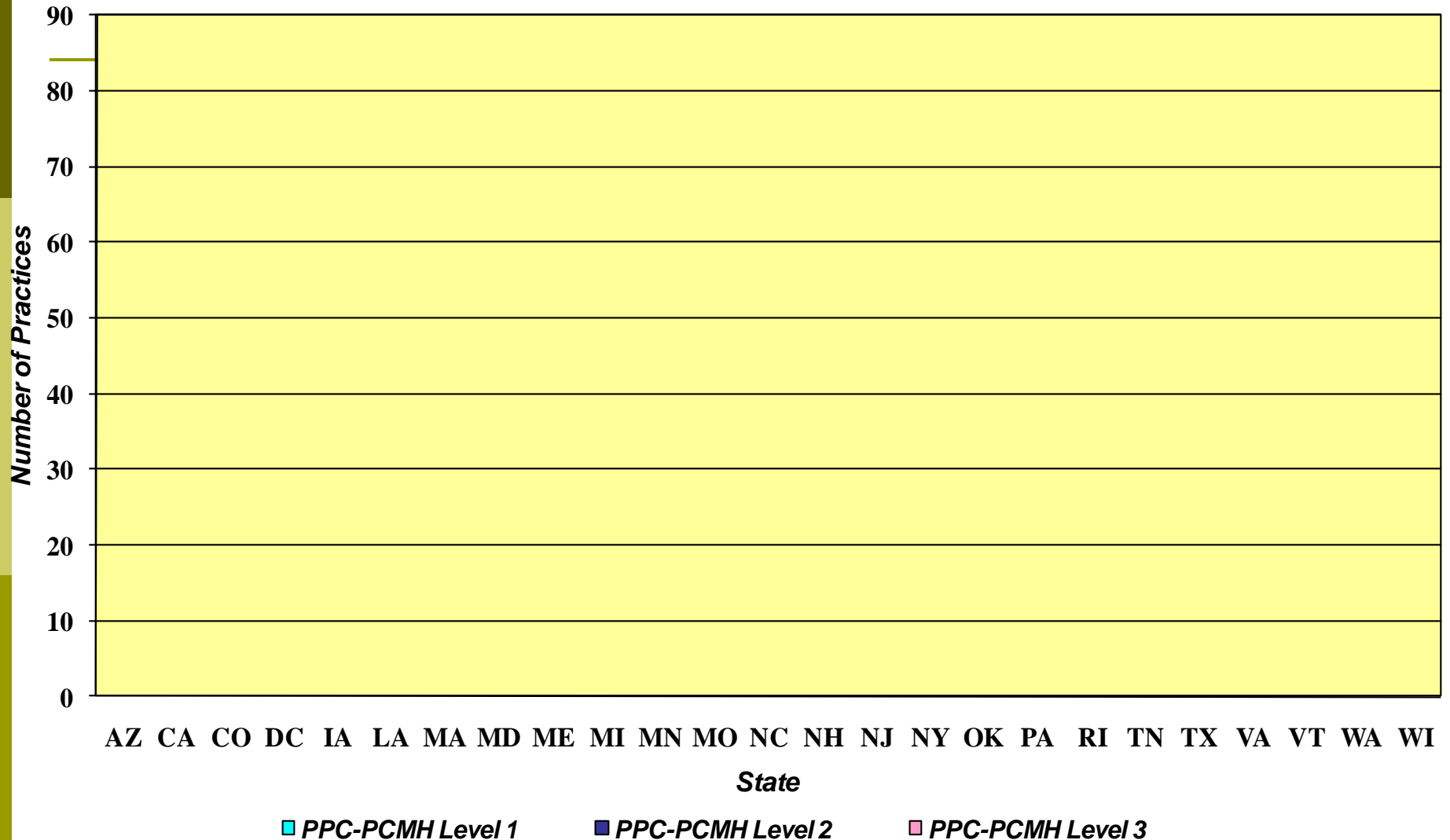


NCQA

Scoring: Building a Ladder to Excellence



NCQA PPC-PCMH RECOGNIZED PRACTICES BY STATE



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

Federal PCMH Efforts: Medicare FFS

Medicare “Advanced Primary Care” Demonstration Project

- In June 2010, HHS and CMS invited states to apply for participation in the Multi-payer Advanced Primary Care Practice Demonstration, an opportunity to assess the effect of advanced primary care practice, when supported jointly by Medicare, Medicaid, and private health plans.

CMS/Health Services and Resources Administration (HRSA)

- Announced by President Obama on December 9, 2009
- Will evaluate the impact of the advanced primary care practice model on the accessibility, quality, and cost of care provided to Medicare beneficiaries served by Federally Qualified Health Centers (FQHCs).

CMS Activity and the PCMH

CMS has two medical home demonstrations currently in development.

In June 2010, HHS and CMS invited states to apply for participation in the Multi-payer Advanced Primary Care Practice Demonstration, an opportunity to assess the effect of advanced primary care practice, when supported jointly by Medicare, Medicaid, and private health plans.

Overview		
Demonstration	Multi-Payer Advanced Primary Care Practice (MAPCP) Demonstration	Federally Qualified Health Centers (FQHC) Advanced Primary Care Practice Demonstration
Geographic Scope	Expect 6 states	Up to 500 clinic sites
Participants	Practices (MD & NP) participating in state health care reform initiatives promoting ACP	FQHCs (and "look-alikes") serving relatively large numbers of Medicare beneficiaries
Practice Qualifications	Dependent on state program	To be determined
Targeted Beneficiaries	Dependent on state program	Medicare beneficiaries receiving primary care from FQHC
Payment	Established by state multi-payer reform initiative	Medicare all-inclusive rate plus monthly care management fee



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



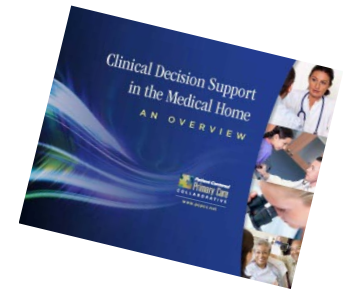
IT Guide



Purchaser Guide



Payment Reform Guide



Clinical Decision Support Guide



Pilot Guide



Consumer Guide

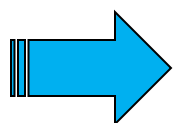
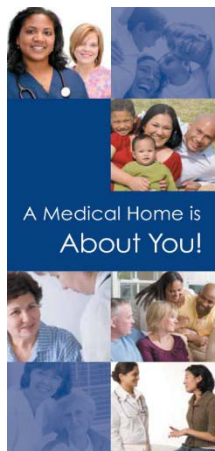


Medication Management Guide

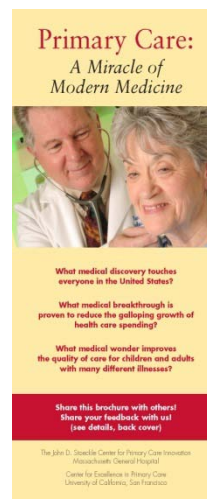
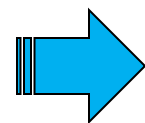


Participatory Engagement Guide

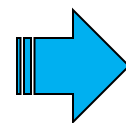
Information Flow- Consumer Materials



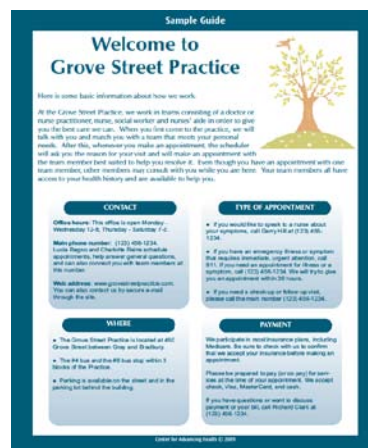
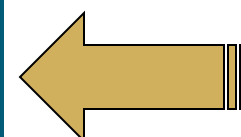
Four minute video for waiting room viewing; deep-dive on PCMH (Flash)



Promotes Primary Care (brochure)



Deep-dive focus on PCMH (brochure)



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

What consumers can expect- PCMH consumer principles (brochure)

Test Drive the New PCPCC Website !

- ❑ Soft Launch 3.18.2010
- ❑ Membership Webinar 4.08.2010 -Recorded
- ❑ 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



The screenshot shows the PCPCC website homepage. The header features the PCPCC logo (Patient-Centered Primary Care COLLABORATIVE) on the left and navigation links (Home, Login, Contact Us) and a search bar on the right. Below the header is a horizontal menu with categories: Pilots & Demonstrations, Consumers & Patients, Employers & Health Plans, Providers & Clinicians, and Federal & State Government. The main content area is dominated by a large banner for the 'March 30th Stakeholders Registration - Cultivate the PCMH' event, titled 'Cultivate the PCMH "What Really Matters" MARCH 30, 2010'. The banner includes the location 'RONALD REAGAN BUILDING INTERNATIONAL TRADE CENTER WASHINGTON, D.C.' and a 'Join & Support' button. To the left of the banner is a sidebar with sections: 'User login' (Login/Register), 'Sections' (Who We Are, What We Do, How We Operate, Get Involved/Donate), and 'Topics' (Behavioral Health, Building the Team, Care Coordination, Health Information Exchange/HIT, Workforce Development, Reimbursement Reform, Legislative Policy, Evaluation/Evidence of Impact). Below the banner are two columns: 'Latest and Popular Content' with 'Latest' and 'Popular' tabs, and 'PCPCC Announcements' with a 'Latest Announcement in order by date' section.

<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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