Update on the Health/Medical Home

STAR Kids Advisory Committee
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We've come a long way baby – or have we?

- The first known documentation of the term "medical home" appeared in Standards of Child Health Care published by the AAP in 1967
- It defines a medical home as one central source of a child's pediatric records and emphasizes the importance of centralized medical records to CSHCN.
- "For children with chronic diseases, the lack of a complete record and a 'medical home' is a major deterrent to adequate health supervision. Wherever the child is cared for, the question should be asked, 'Where is the child's medical home?' and any pertinent information should be transmitted to that place"

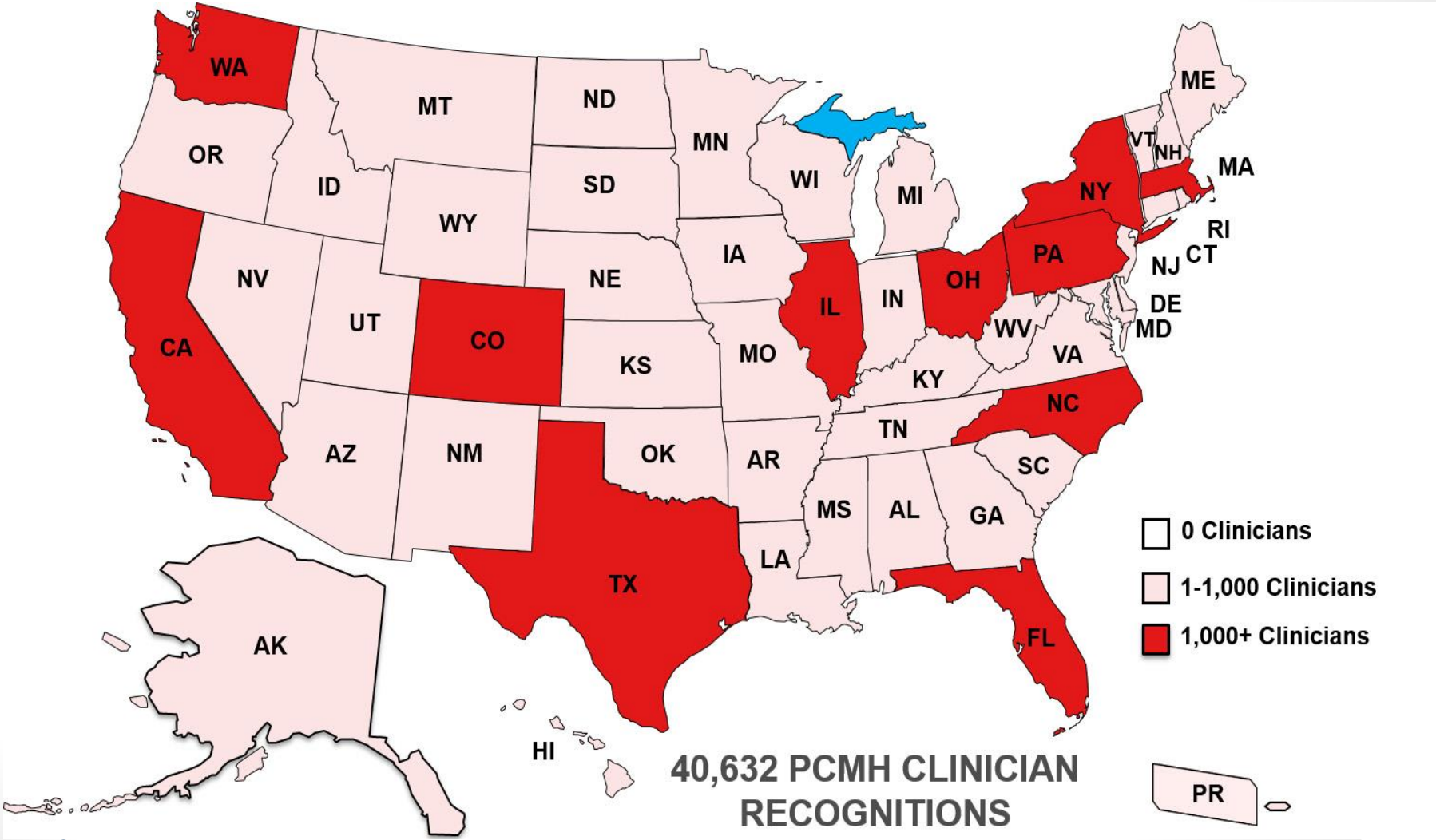
1970s-2007

- AAP expands its statement
- IOM mentions medical home
- AAFP embarks on “Future of Family Medicine” project
- ACP develops “Advanced Medical Home” concept
- AAFP undertakes National Demonstration Project
- AAFP, AAP, ACP and AOA publish Joint Principles of the Patient-Centered Medical Home

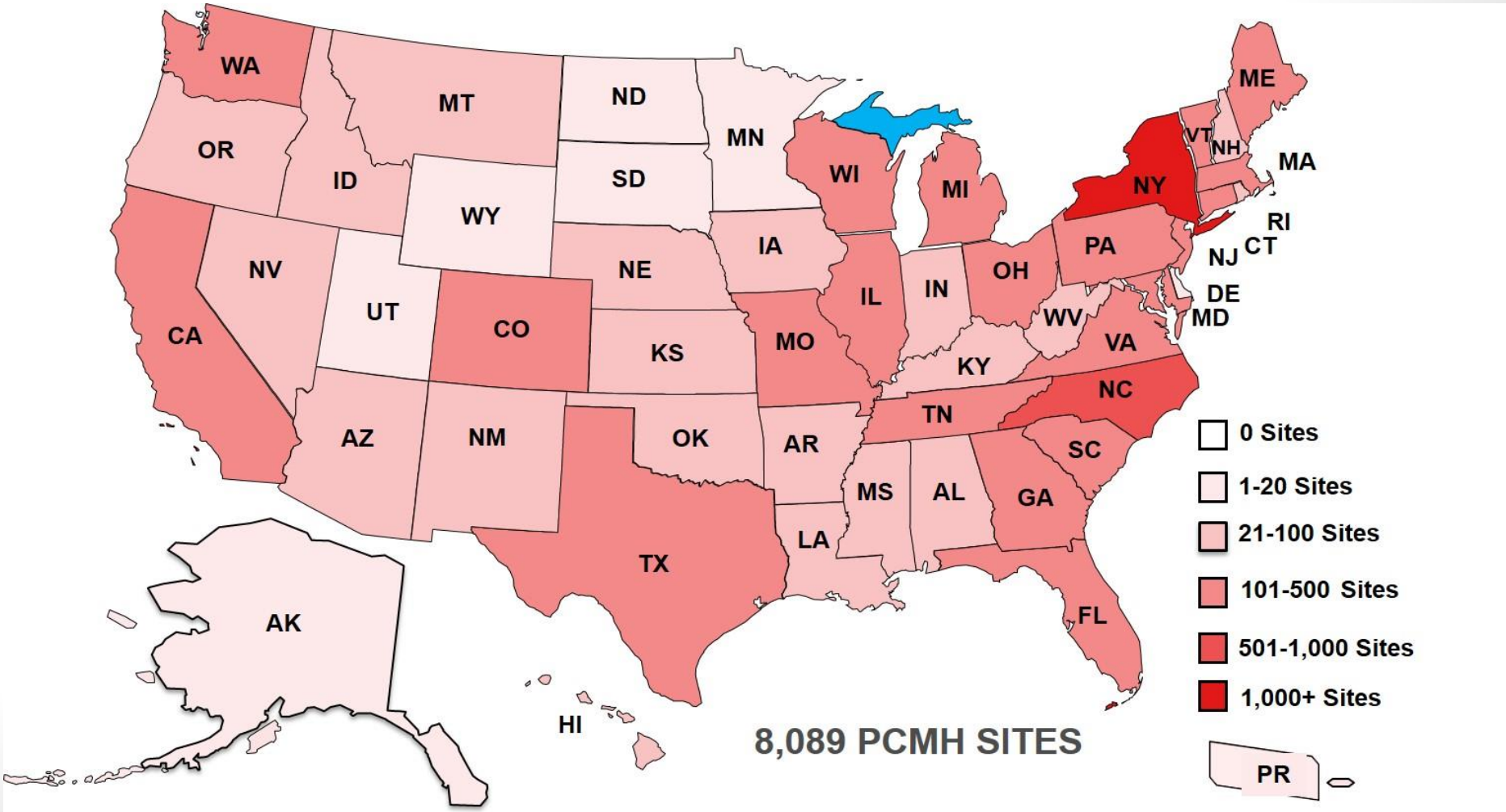
2008-

- First multi-payer PCMH pilots begin in Colorado, Maine, Michigan, North Carolina, Pennsylvania and Rhode Island
- Other organizations including Geisinger and Group Health began pilots along with many single-payer pilots
- Patient-Centered Primary Care Collaborative is established
- NCQA releases its PCMH recognition standards

40,632 PCMH clinicians have earned NCQA Recognition

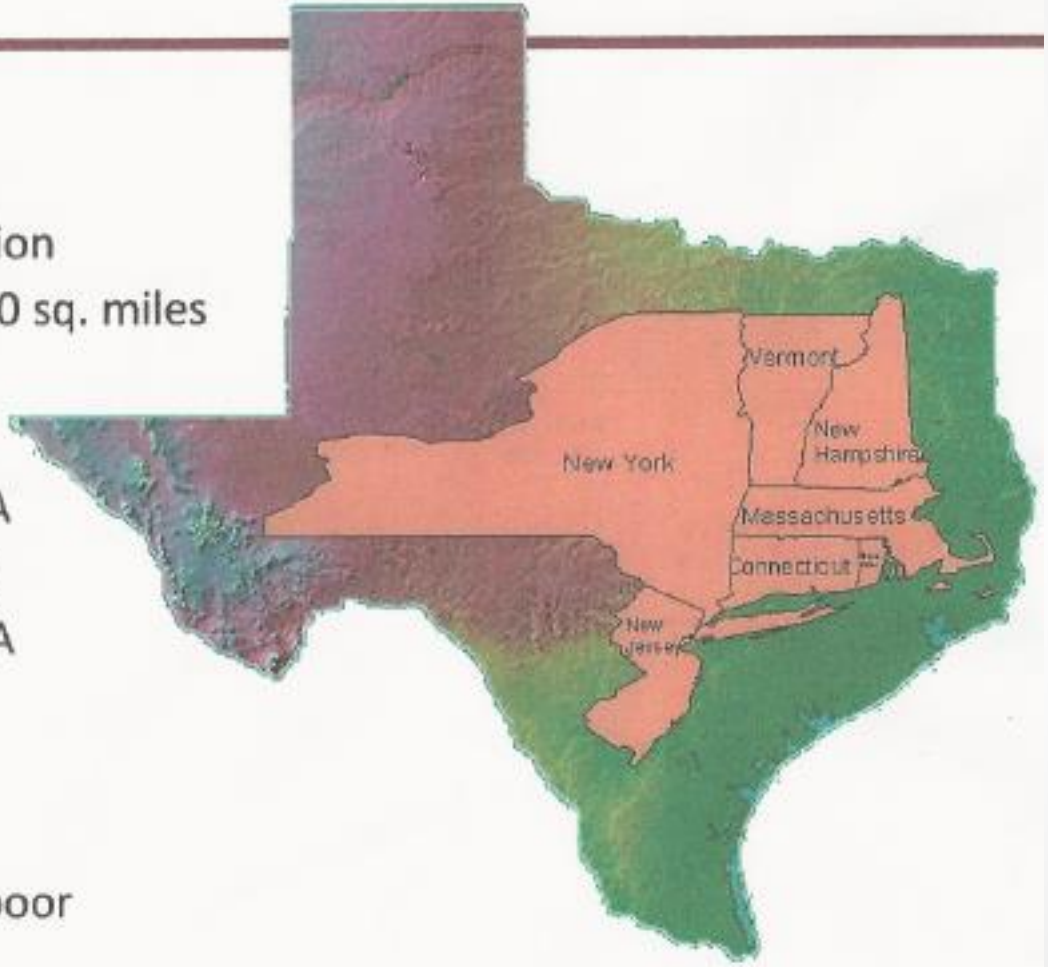


Over 8,000 PCMHs have earned NCQA Recognition

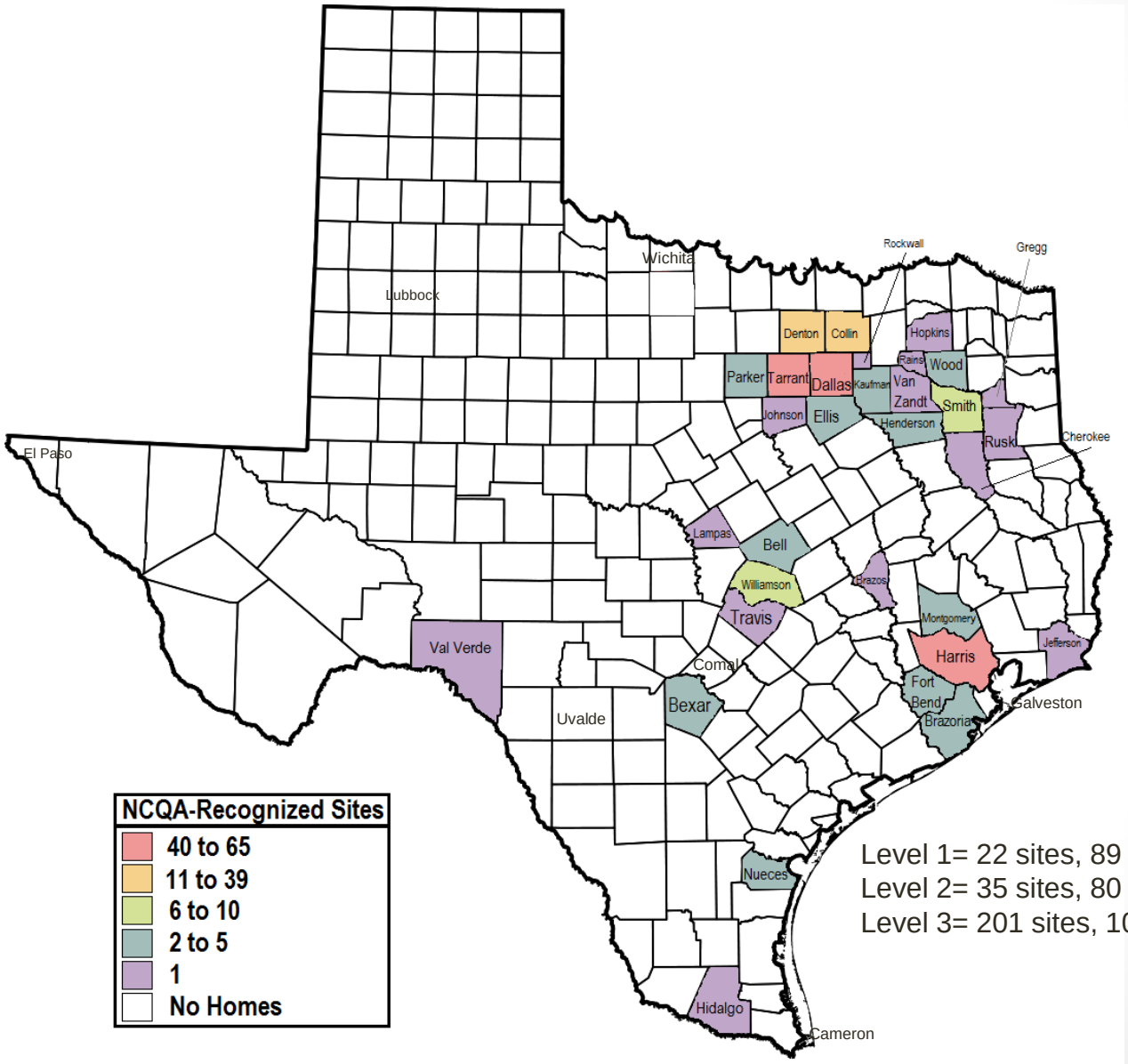


Texas presents unique challenges

- Large state
- Second most:
  - Populated state: 25 million
  - Geographic size: 268,500 sq. miles
- Most:
  - Urban state in the USA
  - Frontier state in the USA
  - One of the most racially diverse states in the USA
  - Un-insured: 25%
- Unique Challenges
  - International Border
  - Very wealthy and very poor
  - Language



NCQA-Recognized PCMHs in Texas, Levels 1-3



Level 1= 22 sites, 89 clinicians
Level 2= 35 sites, 80 clinicians
Level 3= 201 sites, 1084 clinicians

By Mary Takach

Reinventing Medicaid: State Innovations To Qualify And Pay For Patient-Centered Medical Homes Show Promising Results

ABSTRACT This article describes patient-centered medical home initiatives that seventeen states have launched. These initiatives use national recognition or state-based qualification standards along with incentive payments to address soaring costs and lagging health outcomes in state Medicaid programs. Even though these initiatives are in their infancy, early results are encouraging. Modest increases in payment to physicians, aligned with quality improvement standards, have not only resulted in promising trends for costs and quality, but have also greatly improved access to care. Several state programs have already demonstrated declines in per capita costs for patients enrolled in Medicaid; increased participation of physicians in caring for Medicaid patients; and high patient and provider satisfaction. These early results give states good reason to continue developing patient-centered medical homes as part of their Medicaid programs. This article provides a closer look at these innovative models, to inform public and private reform efforts.

Colorado Medicaid and SCHIP Program

- Colorado legislature required single-tier qualification standards
- Legislature gave state Public Health Department and Medicaid program responsibility for developing a system and standards
- Thousands of Colorado families were unable to find primary care providers who accepted Medicaid and CHIP
- State officials worried that the high bar of NCQA could worsen the situation by excluding many small practices
- They combined elements of the 2008 NCQA and other standards

Colorado Medicaid and SCHIP Program

- Practices receive on-site technical assistance
- Providers received enhance FFS payment
- To qualify, practices must undertake a QI project of their choosing annually
- Requirements are:

✓ 24/7 access

✓Open access system or similar convenient scheduling

✓Practices provide care coordination services

Colorado Medicaid and SCHIP Program

- In fiscal 2007-2009, the pilot reported cost savings of $215 per member per year
- 90% of parents had little or no trouble getting appointments when needed
- Provider participation in CHIP increased from 20% to 96%
- Well-care visits for children increased from 54% in 2007 to 73% in 2009

What about Texas?

- Small practices (less than 5 practitioners) still predominate, especially in smaller towns and rural areas
- As a rule, smaller practices have less resources BUT are more nimble in terms of making changes in practices
- Studies have demonstrated that small practices are capable of making changes to their practices to become health/medical homes
- But they need support and infrastructure support to do so!

DSRIP projects to watch

- **Trinity Mother Frances (Tyler):**

✓ Expand and enhance capacity of providers in the region to manage complex pediatric patients locally through timely access to pediatric subspecialists and specialists via telemedicine

- **UTMB (Galveston and Brazoria County):**

✓ Expand primary care capacity for the pediatric population on Galveston Island and decrease inappropriate use of the ED by expanding the pediatric urgent care clinic including physician expansion as well as increase in staffing and clinic hours

DSRIP projects to watch

- **Spindletop Center (Beaumont):**

✓ Provide early intervention and intensive inpatient services and support for youth with behavioral health issues by opening a 16-bed short term inpatient/residential treatment center for youth in Jefferson, Orange, Hardin and Chambers counties

- **Angleton-Danbury Hospital District (Angleton):**

✓ Expand capacity of pediatric primary care to better care for the region's asthmatic children

Closing thoughts

- Health care cost containment cannot be achieved without delivery system transformation across multiple aligned payers
- Delivery system transformation is predicated on access to high quality primary care and supporting services
- High quality primary care is more likely to occur in a consistently supported and formally recognized PCMH setting
- The creation and nurturing of primary care transformation can only be successful in a uniformly applied multi-payer model with collaborative learning and team-based care