Putting Patients and Families at the Center of Care: Innovative State Strategies for Medical Homes and Health Homes

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National Academy for State Health Policy
National Medical Home Summit
March 14, 2013
Philadelphia, PA
Presentation Outline

- Describe the role of states as PCMH innovators
- Discuss policy strategies underway to integrate patients and families into PCMH
- Describe opportunities for you to partner with states to advance these initiatives
NASHP

- 26-year-old non-profit, non-partisan organization
- Offices in Portland, Maine and Washington, D.C.
- Academy members
  - Peer-selected group of state health policy leaders
  - No dues—commitment to identify needs and guide work
- Working together across states, branches and agencies to advance, accelerate and implement workable policy solutions that address major health issues
A Few NASHP Projects Supporting State Medical Homes and Primary Care Initiatives

- Commonwealth Fund: Advancing Medical Homes in Medicaid/CHIP
  - Round I 2007-2009 (CO, ID, LA, MN, NH, OK, OR, WA)
  - Round II 2009-2010 (AL, IA, KS, MD, MT NE, TX, VA)
  - Round III 2011-2012 (AL, CO, MD, MA, MI, MN, NM, NY, NC, OK, OR, RI, VT, WA)
  - Round IV 2012-2014: Advancing multi-payer initiatives (MT, NE, PA, WV)

- Centers for Medicare and Medicaid Services
  - With RTI, evaluation for the Multi-payer Advanced Primary Care Practice Demonstration
  - With NORC, interim evaluation to Congress for Section 2703 Health Homes

- Federal Health Resources and Services Administration 2011-2014
  - National Organization of State and Local Officials Cooperative Agreement to engage Medicaid Directors and HRSA grantees
Medical homes are just the beginning.

Background Image by Dave Cutler, Vanderbilt Medical Center
(http://www.mc.vanderbilt.edu/lens/article/?id=216&pg=999)
Patient Centered Medical Homes (PCMH)

Key model features:
- Multi-stakeholder partnerships
- Qualification standards aligned with new payments
- Practice teams
- Health Information Technology
- Data & feedback
- Practice Education

Graphic Source: Ed Wagner. Presentation entitled “The Patient-centered Medical Home: Care Coordination.” Available at:

www.improvingchroniccare.org/downloads/care_coordination.ppt
Medicaid PCMH Payment Activity

As of March 1, 2013

- Making medical home payments (29)
- Payments based on provider qualification standards (26)
- Payments based on provider qualification standards, making payments in a multi-payer initiative (19)
- Participating in MAPCP Demonstration (8: ME, MI, MN, NY, NC, PA, RI, VT)
- Participating in CPC Initiative (7: AR, CO, NJ, NY, OH, OK, OR)
States are leveraging qualification standards to drive system goals

- 26/29 states align PCMH payments with qualification standards
- Most have added state-developed qualification standards that reach beyond NCQA PCMH
  - Maine expects medical homes to include at least two patients or family members to be a part of the practice leadership team
  - Minnesota requires providers to actively engage with patients in care plan development, shared decision making, and care transition
Patient and Family Engagement

- Engaging patients and families during program development
  - Minnesota’s Consumer/Family Advisory Council
- Measuring patient satisfaction after implementation
  - Rhode Island ties a portion of their payment to CAHPS results
Shared Decision Making (SDM)

Providers and patients working collaboratively to decide among multiple treatment options with the use of patient decision aids

- **Massachusetts:**
  - 2012 legislative requirement that future medical home and certification standards encourage SDM

- **Minnesota:**
  - Regulatory requirement that SDM is included in the state’s medical home standards
    - SDM is also including in the definition of “Patient and Family Centered Care”
Patient Education and Self-Management

- Educating patients to manage their own care at home and in the community
  - Examples:
    - Stanford Chronic Disease Self-Management Program
    - Training care managers in motivational interviewing
    - Shared medical appointments/group visits

- Massachusetts:
  - Massachusetts medical home core competencies

- Oregon:
  - Patient-centered primary care home requires patient and family education, health promotion and prevention, and self-management support efforts
Expanding the medical home model

Making room for teams and new services

Key model features:

- Multi-disciplinary practice teams—often shared among practices
- Payments to teams/networks and qualified providers
- Patients and families “on the team”
- Teams are based in a variety of settings
Supporting Practices to Provide Patient Centered Care

- Community Care Networks/Teams
  - 9 States Used Shared Practice Team Models to Support Primary Care Providers (AL, ME, MN, MI, MT, NC, NY, OK, VT)
  - Integrating & training new providers
    - Peer Specialists, nutrition counselors, etc.
    - Motivational interviewing for care coordinators

- Most states have invested in provider training to help facilitate to “team-based care”

- New curriculum for physicians, nurses and physician assistants
  - Ohio’s Patient-Centered Medical Home Education Pilot
Our Community Care Team will help you set goals to improve your health.

MEET THE COMMUNITY CARE TEAM
A patient-centered medical home fosters a team approach to improving health outcomes for patients. The Community Care Team is a group of professionals on the team who will give you the tools and support you need to reach your goals.

The members of the Community Care Team provide multidisciplinary expertise in helping you manage your chronic condition. Each member brings a level of expertise in different areas to help you be as healthy as possible.

FREE! OUR NURSE WILL:
• Conduct a health assessment and screening.
• Work with you to develop strategies to manage your condition.
• Help you manage your medications.
• Provide diabetes education.
• Provide guidance for healthier living.
• Help you set goals to improve your health.
• Provide coaching to help you meet your goals.

FREE! OUR HEALTH EDUCATOR WILL:
• Conduct a health assessment and screening.
• Work with you to provide guidance and tools for healthier living, such as keeping a food log, and understanding nutrition labels.
• Work with you to develop strategies to manage your condition.
• Help you set goals to improve your health.
• Provide coaching to help you meet your goals.

FREE! OUR COMMUNITY RESOURCE SOCIAL WORKER WILL:
• Conduct a health assessment and screening.
• Connect you with community/financial resources.
• Assist you or a loved one with long-term care planning.
• Work with other agencies to coordinate care.
• Help you set goals to improve your health.
• Provide coaching to help you meet your goals.

OUR BEHAVIORAL HEALTH SOCIAL WORKER WILL:
• Conduct a health assessment and screening.
• Help you identify barriers to meeting your health care goals.
• Help you with coping, relaxation and self-care strategies.
• Help you manage symptoms of anxiety and depression.
• Provide coaching to help you meet your goals.

FREE! A CERTIFIED DIETICIAN WILL:
• Review your health assessment and screening results.
• Provide diabetes education.
• Provide nutrition information for specific health conditions.

In addition, the Community Care Team will, if appropriate, connect you with an exercise program at the YMCA, which has facilities in Burlington and Winooski. You will receive a program tailored to your needs and you will work with YMCA-certified personal trainers in small, one-hour fitness trainings.
Building Neighborhood Using ACA Sec. 2703 Health Homes
What is a Health Home?

- **Eligible Populations:**
  - 1 Serious Mental Illness
  - 2 Chronic Conditions
  - 1 Chronic Condition with Risk of Second
- **Providers:**
  - Designated providers, teams of healthcare professionals, or health teams
  - Can include behavioral health providers and community health centers
- **Standards:**
  - Accessible, whole-person care
  - Linkages to behavioral and long-term care
- **Health Home Services:**
  - Care Management
  - Care Coordination
  - Health Promotion
  - Transitional Care
  - Individual and Family Support
  - Referral to Community and Social Support Services
- **Payment:**
  - Eight-quarter 90/10 Federal Match
  - Tiered payments allowed
  - Per-member/per-month most common payment methodology to date
## Medical Homes vs. Health Homes

<table>
<thead>
<tr>
<th>Medical Homes</th>
<th>Health Homes</th>
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</thead>
<tbody>
<tr>
<td>Designed for everybody</td>
<td>Designed for eligible individuals with a serious mental illness and/or specific chronic physical conditions</td>
</tr>
<tr>
<td>Primary care provider-led</td>
<td>Primary care provider is a key component, but not necessarily the lead</td>
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<tr>
<td>Primary care focus</td>
<td>Focus on linking primary care with behavioral health and long-term care</td>
</tr>
<tr>
<td>No enhanced Medicaid match</td>
<td>Eight-quarter enhanced Medicaid match</td>
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ACA Section 2703 Health Home Activity

As of March 1, 2013

Note: States with stripes have both

Approved State Plan Amendment (10)
Planning Grant (17)
Health Homes Driving Care Integration

- Single care plan shared across all members of the patient’s care team
  - All states with a health home program have this requirement

- Co-location/Care Integration
  - Missouri: Consulting physicians in community mental health centers and behavioral health professionals in primary care offices
  - Wisconsin: included dentists as part of the health home team
Integrated system models

Key model features:

- High-performing primary care providers
- Emphasis on coordination across providers in the health care system
- Shared goals & risk
- Population health management tools
- Health information technology & exchange
- Engaged patients
http://www.nashp.org/state-accountable-care-activity-map
Oregon Coordinated Care Organizations (CCOs) Payment Model

- Authorized by the legislature in 2012 via SB 1580
- Each CCO receives a fixed global budget for physical/mental/ (ultimately dental care) for each Medicaid enrollee
  - CCOs must have the capacity to assume risk
  - Implement value-based alternatives to traditional FFS reimbursement methodologies
- CCOs to coordinate care and engage enrollees & providers in health promotion
- 13 CCOs are operating in communities around Oregon as of 9/2012. Pending final approval, 3 more CCOs will begin enrolling clients on 11/2012
- Meet key quality measurements while reducing the growth in spending by 2% over the next 2 years
What have we learned?

- States have demonstrated a commitment and a unique role in advancing primary care
- Embedded nurse care managers = secret sauce
- Practice transformation takes time and resources
- Data challenges are significant
- Leadership cannot be underestimated
- Cost savings are uncertain, yet states are not turning back
- Partnerships are critical
For More Information

Please visit:

- www.nashp.org
- http://nashp.org/med-home-map
- www.statereforum.org
- www.pcpcc.net

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