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

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NASHP’s Medical Home Work

NASHP:
• Non-profit, non-partisan health policy organization formed in 1987
• Mission: Helping states achieve excellence in health policy

Medical Home Projects:
• Four rounds of technical assistance over the past six years supported by The Commonwealth Fund (25 states in total)
• AHRQ North Carolina IMPaCT – Primary Care Redesign
• Federal Evaluations
  • Health Homes
  • Multi-Payer Advanced Primary Care Practice Demonstration
State Roles

• What roles does a state have to promote advanced primary care models?
  • Purchaser
  • Regulator
  • Educator
  • Public Health

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

**Medical Homes**
- Designed for everybody
- Physician-led
- Primary care focus
- No enhanced Medicaid match

**Health Homes**
- Designed for eligible individuals with a serious mental illness and/or specific chronic physical conditions
- Physician is a key component, but not necessarily the lead
- Focus on linking primary care with behavioral health and long-term care
- Eight-quarter enhanced Medicaid match

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**Medicaid Medical Home Payment Activity**

As of February 1, 2013

- Making medical home payments (28)
- Payments based on provider qualification standards (25)
- 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)
Patient and Family Leadership

- Engaging patients and families during program development
  - Minnesota’s Consumer/Family Advisory Council

- Engaging patients and families in the practices
  - Maine expects medical homes to include at least two patients or family members to be a part of the practice leadership team

- Measuring patient satisfaction after implementation
  - Rhode Island ties a portion of their payment to CAHPS results
Shared Decision Making (SDM)

- 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 included 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:
  - Oregon patient-centered primary care home must-pass element
How States are Supporting Practices

Redesigning Medical Education and Training
• New curriculum for physicians, nurses and physician assistants
  • Ohio’s Patient-Centered Medical Home Education Pilot

Redesigning the Care Team
• Community Care Networks/Teams
  • Alabama, Maine, Oklahoma, North Carolina, and Vermont are just some examples
• Integrating new providers
  • North Carolina and Alabama: Pharmacists
  • Rhode Island and Ohio: Peer Specialists

Redesigning Payment
• Supporting and rewarding practice transformation
  • Connecticut’s “Glide Path” to NCQA PCMH recognition

Integrating Care

• 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
Sharing Data Across the Entire Care Team

- Leveraging health information technology
  - Missouri’s statewide web-based portal for Medicaid providers

- Simplifying patient consent
  - New York developed a single consent document that covers all of a patient’s health information that can be shared under state and federal law

Note: Some states may need to amend privacy laws if the state law is more restrictive than federal law
- HIPAA, FERPA, 42 CFR Pt. 2

What’s Next

- Continued growth of public-private multi-payer medical homes
  - State Innovation Models Initiative
  - NASHP’s public-private multi-payer medical home collaborative

- Medical homes are a foundation for accountable care organizations
Takeaways

• States have demonstrated a commitment to advancing primary care

• States are not doing this work alone

• Practice transformation takes time and resources

• Don’t forget about the special populations in your state—especially pediatrics

NASHP’s Resources

Medical Home Map

• State Overviews
  • Forming Partnerships
  • Defining and Recognizing Medical Homes
  • Aligning Reimbursement and Purchasing
  • Supporting Practices
  • Measuring Results

http://www.nashp.org/med-home-map

Accountable Care Activity Map

• State Overviews
  • Authority
  • Criteria for Participation
  • Governance
  • Measurement and Evaluation
  • Payment
  • Project Scope
  • Support for Infrastructure

http://www.nashp.org/state-accountable-care-activity-map
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