National Medicaid Congress
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ACHIEVING THE PROMISE OF THE CHILDREN'S MEDICAID BENEFIT THROUGH AN INTEGRATED HEALTH CARE DELIVERY SYSTEM

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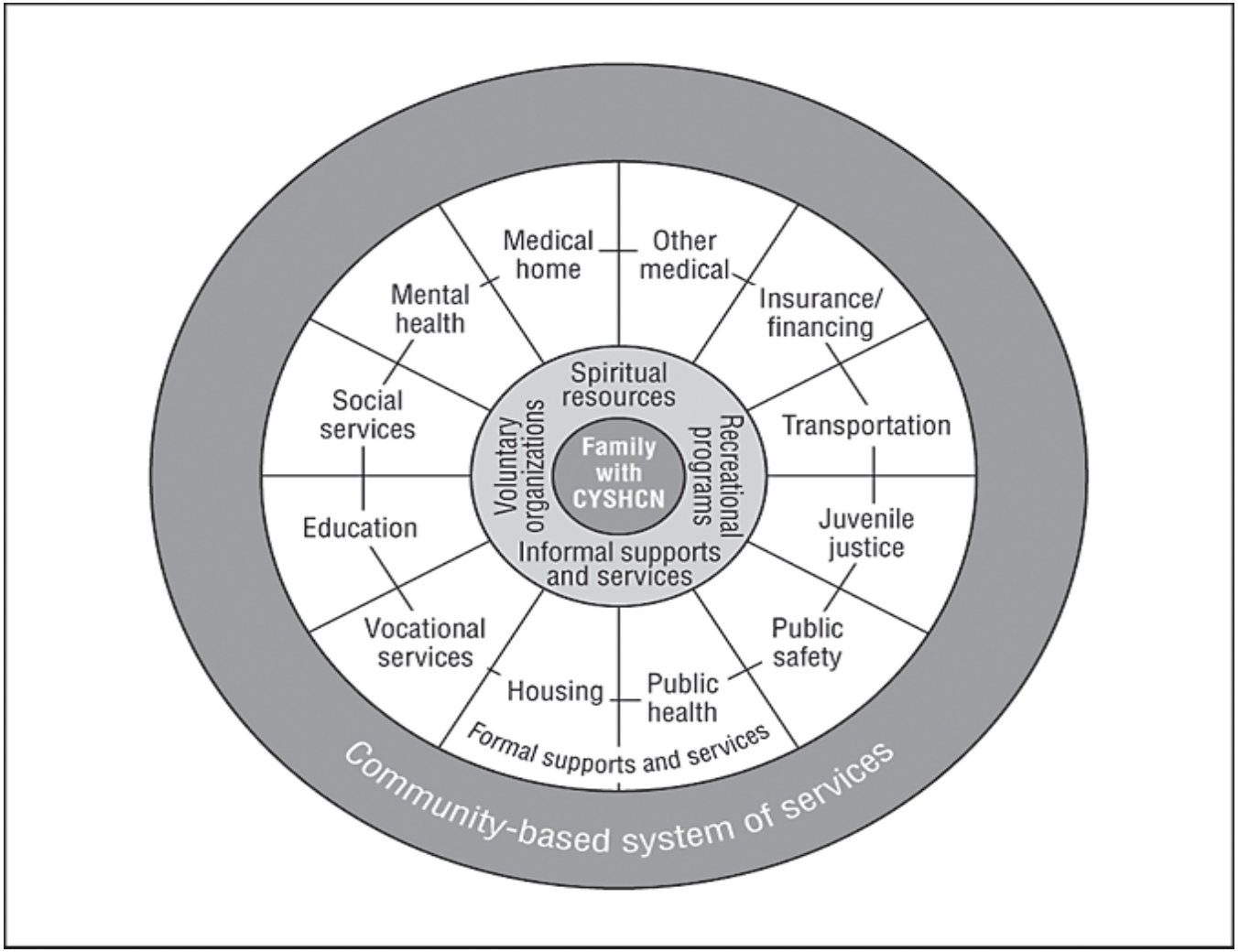
AMERICAN ACADEMY OF PEDIATRICS

- No financial relationships to disclose or conflicts of interest to resolve.
- This presentation will not involve discussion of unapproved or off-label, experimental or investigational uses of drugs or devices.

The Need: Family-Centered Community-based System of Services for Children and Youth



Perrin, J. M. et al. Arch Pediatr Adolesc Med 2007;161:933-936.

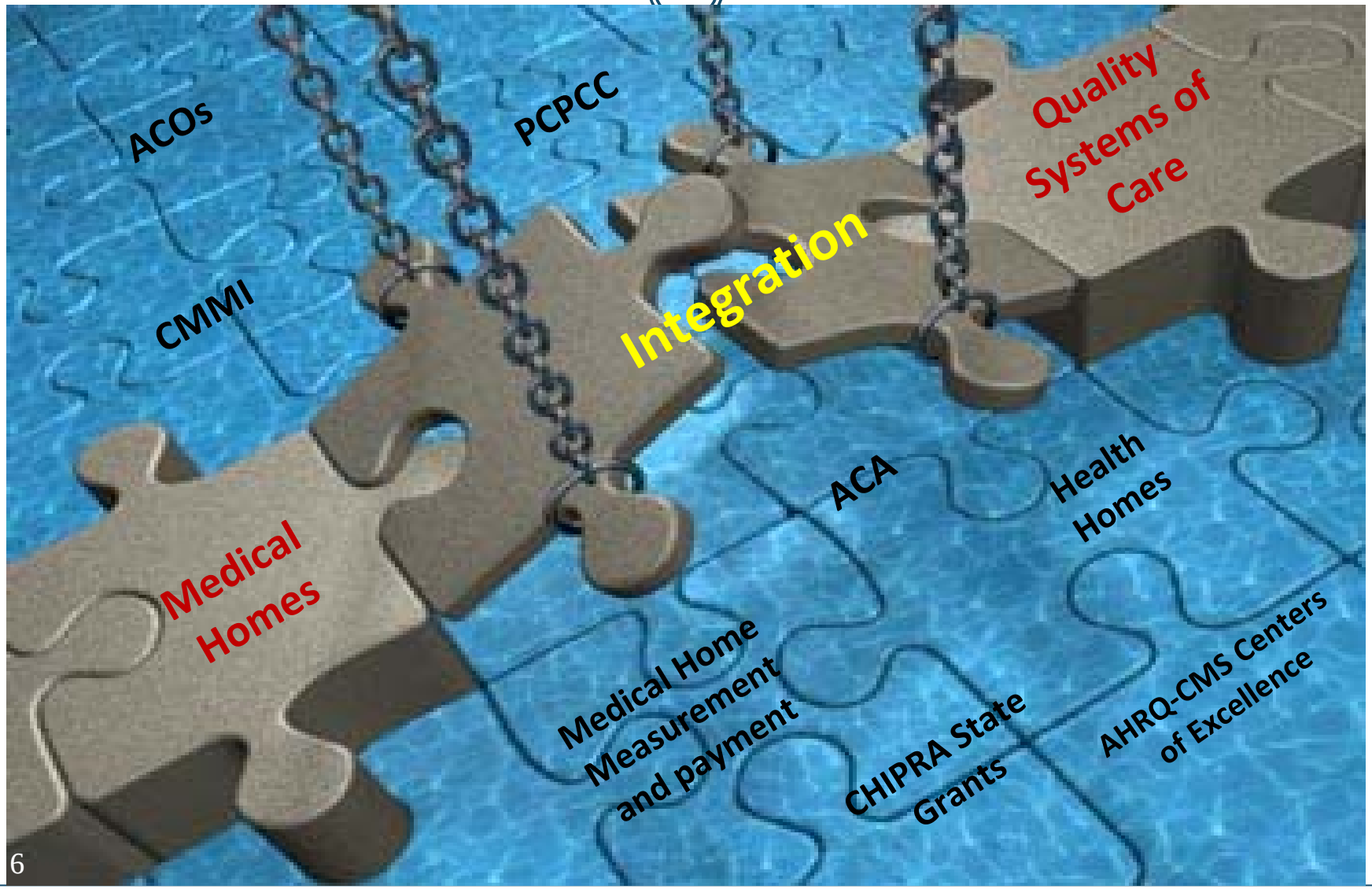
Medical Home Definition

- Primary care
- Family-centered Partnership
- **Community-based interdisciplinary, team-based approach to care**
- Care that is: accessible, family-centered, coordinated, compassionate, continuous and culturally effective
- **Preventive, acute and chronic care**
- Quality care

Integrated Health *System*

- Patients and Families
- Primary Care Providers
- Specialists and subspecialists
- Hospitals and Healthcare Facilities
- Public Health
- Community

Medical Home and Quality - Bridging the Care Continuum



2013 National Initiatives

- Patient-Centered Primary Care Collaborative
- Affordable Care Act (ACA): Health Homes
- Accountable Care Organizations
- Center for Medicare and Medicaid Innovation
- CHIPRA Quality Demonstration Programs
- Measurement of Medical Homes: Practice Recognition

Patient Centered Primary Care Collaborative

- Founded in 2006 with medical societies: AAP, AAFP, ACP and AOA
- Dedicated to “advancing an effective and efficient health system built on a strong foundation of primary care and the patient-centered medical home”
- More than 1,000 stakeholder organizations including businesses, payers, consumer organizations, other physician groups, other healthcare providers

PCPCC Centers

- Advocacy and Public Policy
- *Care Delivery and Integration*
- Employer and Purchaser Engagement
- Outcomes and Evaluation
- *Patients, Families and Consumers*

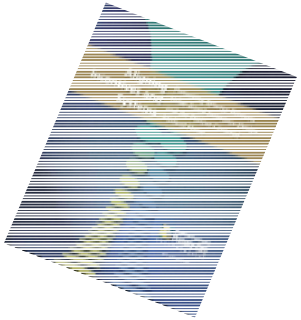
PCPCC Resources

Diabetes Guide

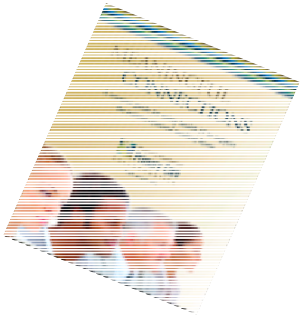
Employer Metrics

Consensus Report

Payment Rate Brief



Value-Based Insurance Design



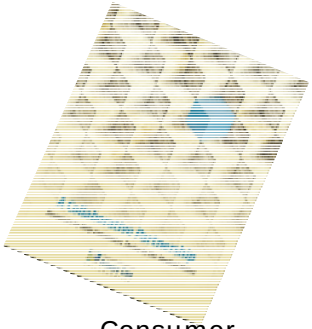
IT Guide

Purchaser Guide

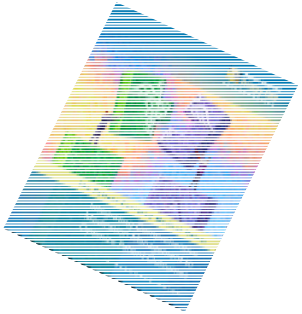
Payment Reform Guide

Clinical Decision Support Guide

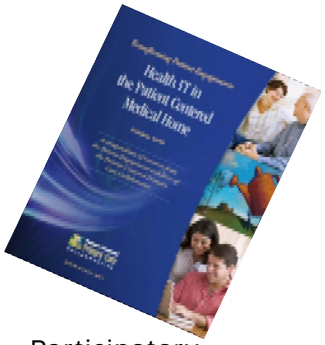
Pilot Guide



Consumer Guide



Medication Management Guide



Participatory Engagement Guide

PCMH – Evidence of Quality

Source: PCPCC (www.pcpcc.net)

ACA: Health Homes

- Section 2703 of the ACA
- Primary Goal: *integration and coordination of physical and behavioral health and long term supports*
- Medicaid State Plan Amendment
- Enrollees with: two or more chronic conditions; one condition and risk of developing another; OR at least one serious and persistent mental health condition
- National Academy for State Health Policy
  - nashp.org/med-home-map

Accountable Care Organizations

- Provider-led organization responsible for the cost and quality for a defined population

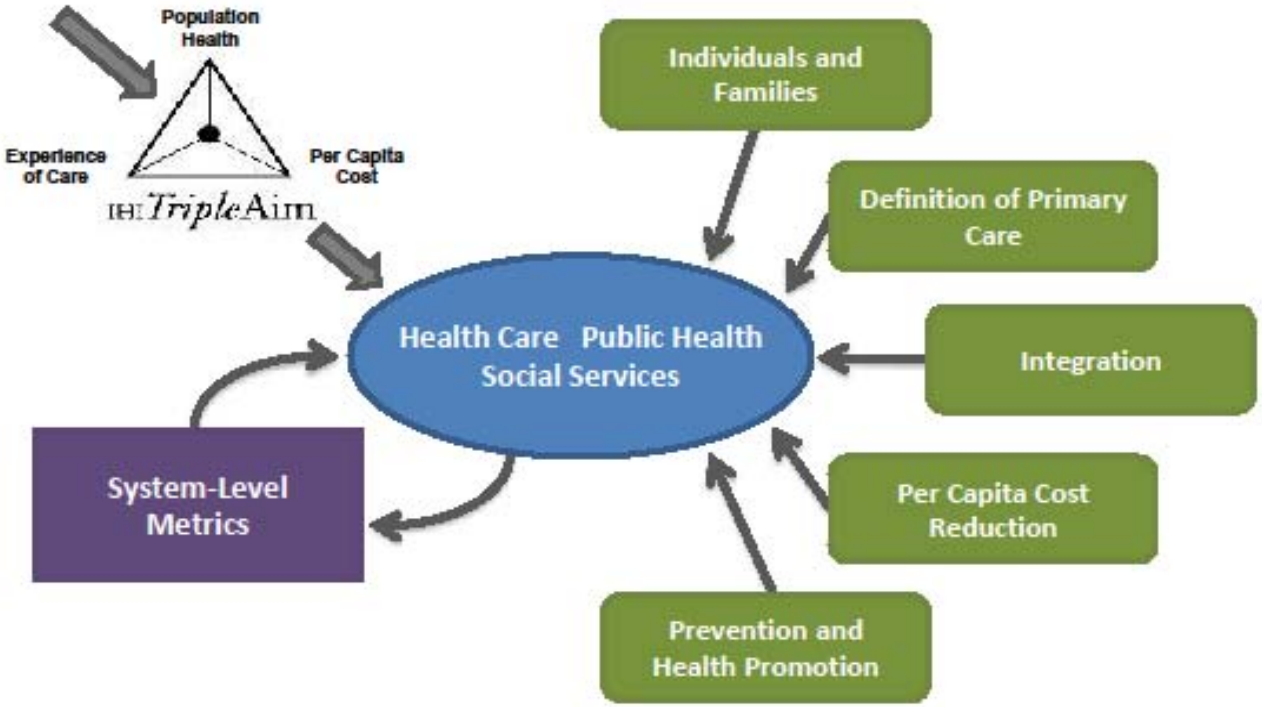
- Major Principles
  - Accountability
  - Shared Savings
  - Performance Measurement

Center for Medicare and Medicaid Innovation

- Institute for Healthcare Improvement (IHI) Triple Aim
  - Experience of Care
  - Population Health
  - Cost
- CMMI Grants
  - 10 are pediatric

Design of a Triple Aim Enterprise

Define "Quality" from the perspective of an individual member of a defined population



Institute for Healthcare Improvement, 2012

CHIPRA Quality Demonstration Grants

- Five general categories:
  - Using quality measures to improve child health care
  - *Applying HIT for QI*
  - Implementing provider-based delivery models
  - Model format for pediatric EHRs
  - Utility of other innovative approaches to enhance quality

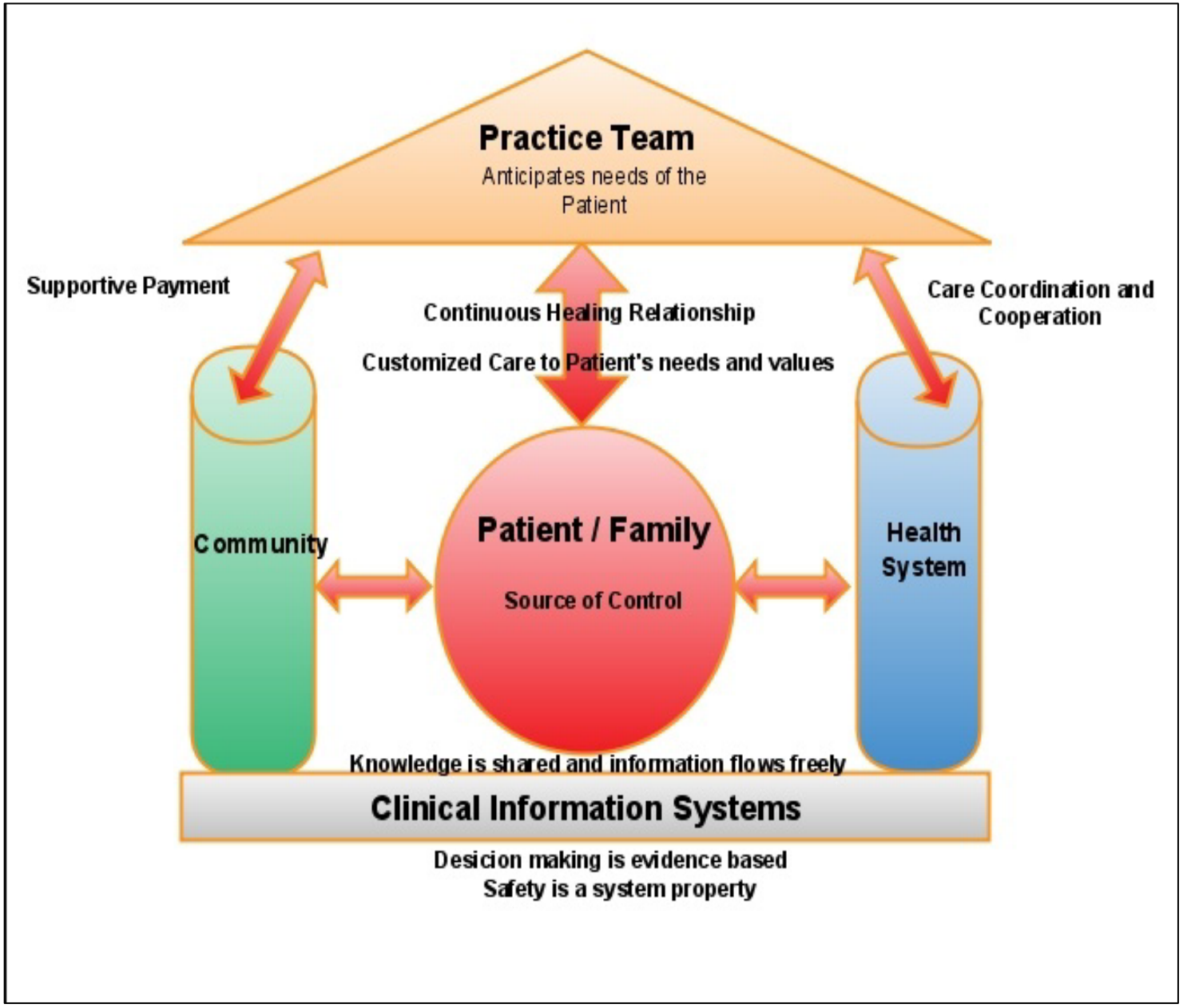
- States: Colorado; Florida; North Carolina; Maine; Maryland; Massachusetts; Oregon; Pennsylvania; South Carolina and Utah

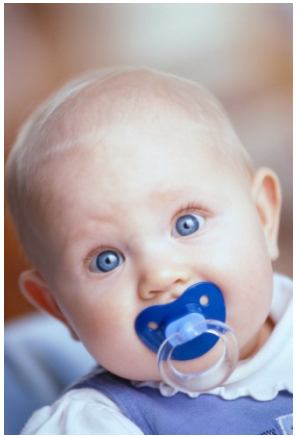
Measurement of “Medical Homeness”

- NCQA: PCMH Recognition Program and Patient-Centered Specialty Practice Recognition
- The Joint Commission
- URAC (Utilization Review Accreditation Commission)
- Accreditation Association for Ambulatory Health Care
- State Medicaid Agencies

2011 NCQA PCMH Recognition

- Enhance Access and Continuity
- Identify and *Manage Patient Populations*
- *Plan and Manage Care*
- Provide Self-care Support and *Community Resources*
- *Track and Coordinate Care*
- Measure and Improve Performance


Practice Team
Anticipates needs of the Patient
Supportive Payment
Continuous Healing Relationship
Customized Care to Patient's needs and values
Care Coordination and Cooperation
Community
Patient / Family
Source of Control
Health System
Knowledge is shared and information flows freely
Clinical Information Systems
Desicion making is evidence based
Safety is a system property



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