Healthy Living/Health Services Subcommittee

Chronic Health Care Homes (HJR 82-2010)

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HJR 82 Study Mandate

- HJR 82 – 2010 (Delegate Hope) directed JCHC to review "programs in other states and to develop recommendations related to:

(i) standards for chronic health care homes which emphasize

(a) the use of a range of primary care practitioners and other professionals including care coordinators to provide high quality, patient-centered care, including development of individualized comprehensive patient care plans, use of patient decision-making aids that provide patients with information about treatment options and associated benefits, consistent contacts between patients and care teams, and systematic patient follow-up,

(b) the use of health information technology,

(c) the use of evidence-based health care practices, and

(d) incorporate quality outcome, and cost-of-care measures;

HJR 82 Study Mandate (Cont.)

- (ii) standards for certification of health care facilities as chronic health care homes including ongoing reporting requirements for chronic health care homes;
- (iii) development of a chronic health care home collaborative to provide opportunities for chronic health care homes and state agencies to exchange information related to quality improvement and best practices;
- (iv) enrollment of state medical assistance recipients with chronic health problems in chronic health care home programs; and
- (v) costs associated with implementing a successful demonstration program to test whether chronic health care homes can improve health care quality and patient outcomes, and reduce costs associated with chronic health problems.

The Joint Commission on Health Care shall complete its meetings for the *first year* by November 30, 2010, and for the *second year* by November 30, 2011."

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Study Background

- Last year we presented the background information addressed in HJR 82, so we will not present that information in detail today.
- At the time this study was introduced, the concept of a PCMH was just beginning to gain attention.
  - However, discussions surrounding new and better ways to provide medical care and a proliferation of demonstrations and pilot programs, indicate that the medical home may become a useful, sustainable model.
- So, we are in the fortuitous position of not having to recommend the creation of any demonstration projects, but to actually monitor what is already happening in the public and private sector.
- This presentation will highlight what is already happening nationally and in Virginia in the medical home arena.

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Chronic Disease Statistics

- Chronic diseases are a leading cause of adult disability and death in the US.
- Expenses for chronic diseases are typically driven by the reoccurrence of acute events, such as emergency room visits, hospitalizations, or costly inpatient and outpatient treatment plans.
- The medical care costs for people with chronic diseases account for more than 75% of the nation's $2 trillion in medical care costs. By 2020, that is expected to rise to 80% of overall health spending.
  www.cdc.gov/nccdphp/overview.htm
- People with chronic conditions account for 88% of all prescriptions filled, 72% of all physician visits, and 76% of all inpatient stays.

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Prevention of Chronic Disease

- There is a growing body of evidence that earlier identification of chronic diseases coupled with preventive care can halt or slow the progression of chronic diseases, thereby improving patient health and well-being while reducing medical costs. (www.aha.org)
- Chronic diseases are the most prevalent, most costly and most preventable of illnesses.
  - Prevention includes interventions such as risk screenings, vaccinations, education on behavior, primary care, disease detection, monitoring and treatment.
    - These activities can significantly reduce disease, disability and death. (www.aha.org)
  - Transforming the system from one that reacts when a person is sick, to one that is proactive and focused on keeping a person as healthy as possible. (www.improvingchroniccare.org)

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Fragmentation

- People with multiple chronic conditions typically receive health and home care services from different systems, often from multiple providers within each system. As a result, the health care delivery system for those with chronic conditions is complex and confusing, and care is often fragmented, less effective and more costly.
- People who receive care from numerous providers often lack the ability to monitor, coordinate or carry out their own treatment plans.
  - Often have multiple health care providers (HCPs), treatment plans and prescriptions written by different physicians who may be unaware of the other providers treating the individual; resulting in unnecessary ER and hospital admissions.
  - About 25% of those with chronic conditions face limitations with activities of daily living such as walking, dressing and bathing.

Source: Robert L. Mollica and Jennifer Gillespie. "Care Coordination for People with Chronic Conditions," Partnership for Solutions, Johns Hopkins University. January 2003.

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Fragmentation

- "Physician groups, hospitals, and other health care organizations operate as silos, often providing care without the benefit of complete information about the patient's conditions, medical history, services provided in other settings, or medications prescribed by other clinicians." Ernest Clevenger, "How Primary Care, America's Best-Kept Secret, Can Reduce Health Care Costs for Self-Funded Employers" HealthWatch, September 2008.
- A new study from the Center for Studying Health System Change revealed:
  - "widespread acknowledgement that most provider payment methods don't encourage efficient or effective delivery of chronic disease care."
  - And, "optimal care for people with chronic disease involves coordinated, continuous treatment by a multidisciplinary team."

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Patient Centered Medical Home

- A number of experts believe that many of the problems identified with the U.S. health system can be solved using the model of a health care home.
- A health care home, or patient centered medical home (PCMH), is an approach in which primary care providers, families and patients work in partnership to improve health outcomes and quality of life for individuals with chronic health conditions and disabilities.
- A major goal of PCMHs is to reduce costs by avoiding duplicate or unnecessary testing and services and result in better quality care at a more affordable cost.

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Components of Patient Centered Medical Home

- Team-based model of care led by a personal physician who provides continuous and coordinated care throughout a patient's lifetime to maximize health outcomes.
- Components include:
  - Each patient receives care from a personal physician who leads a team of providers who are responsible for planning ongoing care;
  - personal physician responsible for "whole person";
  - patient care coordinated across health system and community;
  - enhanced access to care offered through open scheduling, expanded hours, and new care options such as group visits;
  - payment structure recognizes enhanced value provided to patients.

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Patient Centered Medical Home

- Typically providers who adopt the medical home model receive additional compensation to reflect the change in the delivery of health care services. Some:
  - Receive fee-for-service payments for all services they provide plus additional payments to provide care coordination.
  - Receive additional payments for managing patient care and for meeting or exceeding such quality and performance standards by:
    - implementing electronic health records,
    - e-prescribing,
    - coordinating medication management with pharmacists,
    - tracking test and referrals,
    - providing telephone access after business hours, and the percentage of children who receive well-child visits.

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Joint Principles

- In 2007, the American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, and the American Osteopathic Association came together to identify a set of joint principles for PCMHs at the request of health care purchasers.

- These principles emphasize:
  - Access to a personal physician who directs a medical team responsible for the patient's care.
  - Patient care that has a whole-person orientation, is coordinated across the health care system, and is focused on quality and safety, as well as enhanced access to care.
  - Payment should recognize the added value that physicians and other care providers add.

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National Committee for Quality Assurance Standards

- Standards developed by the National Committee for Quality Assurance (NCQA) are most often used to identify which primary care practices have achieved designation as a medical home.
- The standards allow for recognition as a PCMH at 3 different levels and include 30 elements, of which 10 are considered mandatory or "must pass."
- Practices that achieve NCQA's PCMH Recognition are positioned to take advantage of financial incentives offered by health plans and employers, as well as of federal and state-sponsored pilot programs.
- NCQA updated its standards and published new guidelines in January 2011.

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PCMH Programs

- By the end of 2011, more than 7,600 clinicians at more than 1,500 practices across the country had earned PCMH Recognition.
- Across the country, public and private payers, purchasers and clinicians have created pilot and demonstration programs.
  - Many programs provide financial incentives, such as pay for performance and reimbursement for services beyond the patient visit, which have motivated primary care practices to engage in the transformation that leads to NCQA PCMH recognition.

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Patient-Centered Primary Care Collaborative (PCPCC) Pilot Programs

- The PCPCC recently released a report that summarized findings from PCMH demonstrations and concluded that "investing in primary care patient centered medical homes results in improved quality of care and patient experiences, and reductions in expensive hospital and emergency department utilization…Several major evaluations show that patient centered medical home initiatives produced a net savings in total health care expenditures for the patients served by these initiatives.
- Studies have demonstrated that PCMHs improve access and reduce unnecessary medical costs.

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Geisenger Health System PCMH Model

Example of an integrated delivery system model.

- Demonstrated an 18% reduction in hospital admissions relative to controls:
  - 257 PCMH admissions vs. 313 "control" admissions per 1,000 members per year.
- 7% reduction in total per member/per month costs relative to controls.

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BlueCross BlueShield of South Carolina

Example of a Private Payer Sponsored PCMH initiative

- 10.4% reduction in inpatient hospital days (from 542.9 to 486.5 per 1,000 enrollees per year among PCMH patients).
  - Inpatient days were 36.3% lower among PCMH patients than among control patients.
- 12.4% reduction in emergency department visits (from 21.4 to 18.8 per 1,000 enrollees per month among PCMH patients).
  - Emergency department visits were 32.2% lower among PCMH patients than among control patients.
- Total medical and pharmacy costs per member/per month were 6.5% lower in the PCMH group than the control group.

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Community Care of North Carolina

Example of Medicaid-Sponsored PCMH Initiative

- Consists of 14 regional networks providing medical homes for 1.1 million Medicaid enrollees.
- Each network serves as a virtual integrated health system:
  - Medical management committee of local doctors who develop best practices, a medical director, and a clinical pharmacist.
  - Networks and participating physicians receive at least $2.50 per member/per month to coordinate care.
- Community Care of NC saved the state nearly $1.5 billion in health care costs between 2007 and 2009, according to Treo Solutions, due mainly to reduced hospital admissions and readmissions and improved management of chronic conditions.

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Community Care of North Carolina

- The program has worked so well, they initiated a new pilot program, First in Health, to extend the cost savings and improvements outside the state's Medicaid program.
  - GlaxoSmithKline, retail pharmacist Kerr Drug, and the health plan for NC state employees will offer Community Care medical homes to workers as an optional enhanced benefit for their existing health coverage.
  - $2.50 per member/per month.
  - Most new participants won't need to find new doctors because 95% of primary care physicians in NC already participate in Community Care of NC.

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Federal Health Reform

- The Patient Protection and Affordable Care Act (PPACA) created the Center for Medicare and Medicaid Innovation:
  - Will test innovative payment and service delivery models to reduce the rate of growth of Medicare and Medicaid expenditures.
    - Among the models to be tested are those that promote "broad payment and practice reform in primary care, including PCMH models for high need individuals, medical homes that address women's unique health care needs, and models that transition primary care practices away from fee-for-service based reimbursement and toward comprehensive payment or salary-based payment."
  - Preserve or enhance the quality of care.

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Demonstration Projects

- PPACA authorized the Department of Health and Human Services (HHS) to test medical homes.
  - In June 2010, HHS invited states to apply for participation in the Multi-payer Advanced Primary Care Demonstration Project in which Medicare, Medicaid and private insurers will use the medical home model to assess improvements to the delivery of primary care and lowering health care costs.
    - Eight states were chosen to participate: Maine, Vermont, Rode Island, New York, Pennsylvania, North Carolina, Michigan and Minnesota.
    - The demonstration will ultimately include approximately 1200 medical homes serving as many as 1 million Medicare beneficiaries.
  - The Department of Veterans Affairs, the nations largest health system, has begun shifting its clinics to the medical home model, with transition expected to be complete by 2015.

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Federal Health Reform

- Provides states the option of enrolling Medicaid beneficiaries with chronic conditions into a health home. (Sec. 2703)
  - Allows patients enrolled in Medicaid with at least two chronic conditions to designate a provider as a "health home" to help coordinate treatments for the patient.
  - Provides an opportunity for states to get 90% of the funding in the first 2 years from the federal government.
- Provides grants to develop and operate training programs, provide financial assistance to trainees and faculty, enhance faculty development in primary care and physician assistant programs, and to establish, maintain, and improve academic units in primary care. Priority give to programs that educate students in team-based approaches to care, including the PCMH. (Sec. 5301)

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Federal Health Reform

- Federal HHS has the authority to expand the use of PCMHs within Medicare or Medicaid if it has been shown that these models reduce spending or the growth in spending without reducing quality, or can improve patient care without increasing spending.
- Additionally, federal stimulus funding included incentives to invest in electronic health records (EHRs).
  - Beginning in 2011, hospitals and eligible professionals were allowed to receive incentive payments under Medicare and Medicaid if they make "meaningful use" of EHRs.
  - The new NCQA standards for PCMH recognition are closely in line with these incentives.

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Virginia Department of Medicaid Assistance Services (DMAS)

- DMAS is partnering with the Southwest Virginia Community Health Systems, Community Care Network of Virginia, and Carilion in order to transition a Medicaid primary care case management program in southwestern Virginia into a medical home pilot.
- The medical home pilot, which received a technical assistance grant from the National Academy of State Health Policy and the Commonwealth Fund, will provide primary care, behavioral health, disease and case management, and other services.

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Virginia Innovation Center

- In Virginia, an Innovation Center will be established as a nonprofit center hosted by the Virginia Chamber of Commerce.
- While many of the details of how the Center will operate have not been determined as the projected start date for the Center is January 2012, "the Innovation Center will serve as a resource in Virginia by:
  - Researching and disseminating knowledge about innovative models of health promotion and health care to Virginia employers, consumers, providers, health plans, public purchasers, and communities;
  - Developing multi-stakeholder demonstration projects aimed at testing innovative models of health promotion and health care; and,
  - Helping Virginia employers, providers, purchasers, health plans, and communities accelerate their pace of innovation for the benefit of Virginians."
- (Description sent to JCHC staff by Health and Human Resources Secretariat staff in August 2011.)

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Virginia Primary Care Physicians

Medical home initiatives are being undertaken in Virginia.

- Eighteen Carilion physician practices in the Roanoke and New River valleys are recognized as Level-3 (highest) PCMHs by the National Committee for Quality Assurance.
  - The Family Medicine Group in Vinton was the first practice in Virginia to be certified as a PCMH.
- An increasing number of practices in the Hampton Roads area are transforming themselves into PCMHs.
- Physicians and faculty of Eastern Virginia Medical School will soon apply for recognition as a medical home.
- Several Sentara practices are also in the application process.

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Policy Options

- **Option 1:** Take no action.
- **Option 2:** Continue to monitor the progress of primary care medical homes and other health care innovations in Virginia by including reports on initiatives in the 2012 work plan of the Healthy Living/Health Services Subcommittee.

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Public Comments

- Written public comments on the proposed options may be submitted to JCHC by close of business on October 6, 2011.
- Comments may be submitted via:
  - E-mail: jhoyle@jchc.virginia.gov
  - Fax: 804-786-5538
  - Mail: Joint Commission on Health Care
    P.O. Box 1322
    Richmond, Virginia 23218
- Comments will be summarized and reported during the October 17th meeting.

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