


PATIENT-CENTERED MEDICAL HOME

Building Evidence and Momentum

A compilation of PCMH pilot and demonstration projects

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Trends in health care cost containment are fleeting and enduring solutions are elusive. Over the past two decades of double-digit inflation in medical spending, decision makers have employed a number of strategies to stem the tide. However, they have been swept away by it.

At the same time, quality care, clinical outcomes, and patient satisfaction are on the decline.


Moving away from piecemeal, band aid quick-fixes, the Patient-Centered Primary Care Collaborative (PCPCC)—a coalition of large employers, primary care societies, national health plans, patients’ groups, and others—has united in supporting the “Patient-Centered Medical Home” (PCMH) model of care as a comprehensive solution. The purpose is to offer patients a point of entry primary care team that will provide continuous and coordinated care, helping patients to navigate the esoteric, segmented medical system. By engaging patients with their doctors, they can take real accountability for their health. This will create savvier consumers of care and ultimately better health outcomes.

The PCPCC is more than just a consensus group built around the core values of its formalized Joint Principles. It is a collaboration of like-minded stakeholders actively working to drive the shared vision of a transformed system. This report is produced as a resource document developed by one of four Collaborative Centers of the PCPCC, the Center for Multi-Stakeholder Demonstrations, which has set a goal to share lessons learned and best practices from existing PCMH demonstrations. What you will read in the following pages are ongoing efforts around the country to build the evidence base to prove that the systems we propose as part of the PCMH intervention, outlined in the Joint Principles, lead to cost-savings, better health outcomes, and higher patient satisfaction.

Health policy leaders involved with the Collaborative hold a high level of conviction that the model will deliver superior performance, and indeed in limited rollouts there is already evidence of cost savings from reduced emergency room utilization and reduction of redundant or unnecessary tests and consultations. A recent *Health Affairs* article described reforms instituted by the Geisinger Health System—a Pennsylvania-based health services organization with hospitals, a group practice, and an insurance company—that lead to reduced hospital admissions by 20% and approximately 7% savings across the board in medical costs (Continuous Innovation In [Health Care: Implications Of The Geisinger Experience](#). Paulus et al. *Health Affairs*.2008; 27: 1235-1245). They achieved this in large part by aligning reimbursement incentives for providers to support patient-centric care coordination, facilitated by electronic health records, as called for by the Joint Principles. Because of the Geisinger example and others, purchasers and payers are finding the merits of the PCMH concept to be sufficiently compelling to warrant an investment in pilots or phased implementations that will be subject to formal assessment and evaluation for effectiveness.

Multi-stakeholder pilots that are coordinated across a number of health plans help spread the impact on participating primary care practices. Efficiencies are realized by utilizing collaborative sets of standards and requirements. The power of pilot evaluation metrics is also enhanced by pooling members across multiple payers. Similarly, some single payer pilots—which we have chosen to include—are evaluating metrics that align with those multi-stakeholder efforts.

Many practices will receive credit for transformation on the basis of their ability to provide PCMH systems as recognized by the National Committee for Quality Assurance’s Physician Practice Connections–Patient-Centered Medical Home (PPC-PCMH), outlined in the following pages. We want to reward practice teams that are accountable for providing systems-based care called for by the Joint Principles.



In that vein, we are pleased so many practices have shown the fortitude to lead this movement in its early stages by attempting the intervention we advocate. We recognize their efforts in this listing of current pilot projects—which are in various stages of development—also detailing specific project attributes in an organized, consolidated fashion.

The list is not exhaustive; for example, we have not attempted to include details on a number of public payer (Medicare and Medicaid) pilots that are also focusing on demonstrating the value of the patient-centered medical home. Much work on that front is being done by our colleagues at the National Academy for State Health Policy, a group that is leading discussions occurring at the state level to adopt standards and define metrics associated with providing a true medical home.

They are working closely with the PCPCC's Center For Public Payer Implementation, making sure that in combination with the Collaborative's efforts in the private sector, our message resonates just as strongly with public purchasers of care. The Centers for Medicare and Medicaid Services (CMS) is also pulling its weight on behalf of the federal government, and in 2008 will be rolling out a series of demonstration projects of the PCMH that may include over 200,000 covered Medicare lives.

State legislatures are using the term “medical home” in crafting a variety of health reform legislation. The bills run the gamut and include the formation of state medical home demonstration projects or systems of care pushing medical home legislation to test the model in their states. The latest legislative reports can be found at <http://www.trendtrack.com/taxis/app/viewrpt?event-483e340d37b>.

For updates on all of these public sector initiatives, and to track the evolution of the private sector projects outlined in the following pages, visit the PCPCC website: www.pcpcc.net.

We hope that through learning about PCMH interventions and evaluations occurring around the country, the reader might find himself inclined to get involved in the pilot effort. For those representing health plans or employer purchasers, this might involve integrating portions of covered lives into a pilot program that's just getting started. For quality groups and patient advocates, the PCMH cannot succeed without your outreach and advice. If there is a pilot ongoing in an area in which you are active, please take time to visit the practices, speak with the primary care teams, and share your wisdom in advising us all how we can do a better job of delivering the culturally sensitive care that patients want, need, and will be receptive to.

This is a multi-player, collaborative effort involving all health care stakeholders, some of whom have united despite other conflicting interests. We hope this document will not only serve as an informational resource, but also a Call-To-Action to those interested in the model and wanting to be more involved in proving its value.

Paul Grundy

Paul Grundy, MD, MPH
MD, MPH; Chairman
Patient-Centered Primary Care Collaborative

Edwina Rogers

Edwina Rogers
Executive Director
Patient-Centered Primary Care Collaborative

PCMH Pilot Map

UnitedHealth Group PCMH Demonstration Program (AZ)

Colorado Multi-Stakeholder Multi-State PCMH Pilot (CO)

Wellstar Health System (GA)

Quality Quest Medical Home (IL)

Louisiana Health Care Quality Forum Medical Home Initiative (LA)

Maine Multi-Payer Patient-Centered Medical Home Pilot (ME)

Aligning PCMH Stakeholders in Michigan (MI)

Blue Cross Blue Shield of Michigan—Physician Group Incentive Program (PGIP) (MI)

CIGNA and Dartmouth-Hitchcock Patient-Centered Medical Home Pilot (NH)

NH Multi-Stakeholder Medical Home Pilot (NH)

Patient-Centered Medical Home—Diabetes Management (ND)

MediQhome Quality Project: Patient-Centered Advanced Medical Home Quality Improvement Initiative (ND)

CDPHP Patient-Centered Medical Home Pilot (NY)

EmblemHealth Medical Home High Value Network Project (NY)

New York Hudson Valley p4p/Medical Home Project (NY)

Cincinnati Medical Home Pilot Initiative (OH)

Greater Cincinnati Aligning Forces for Quality Medical Home Pilot (OH)

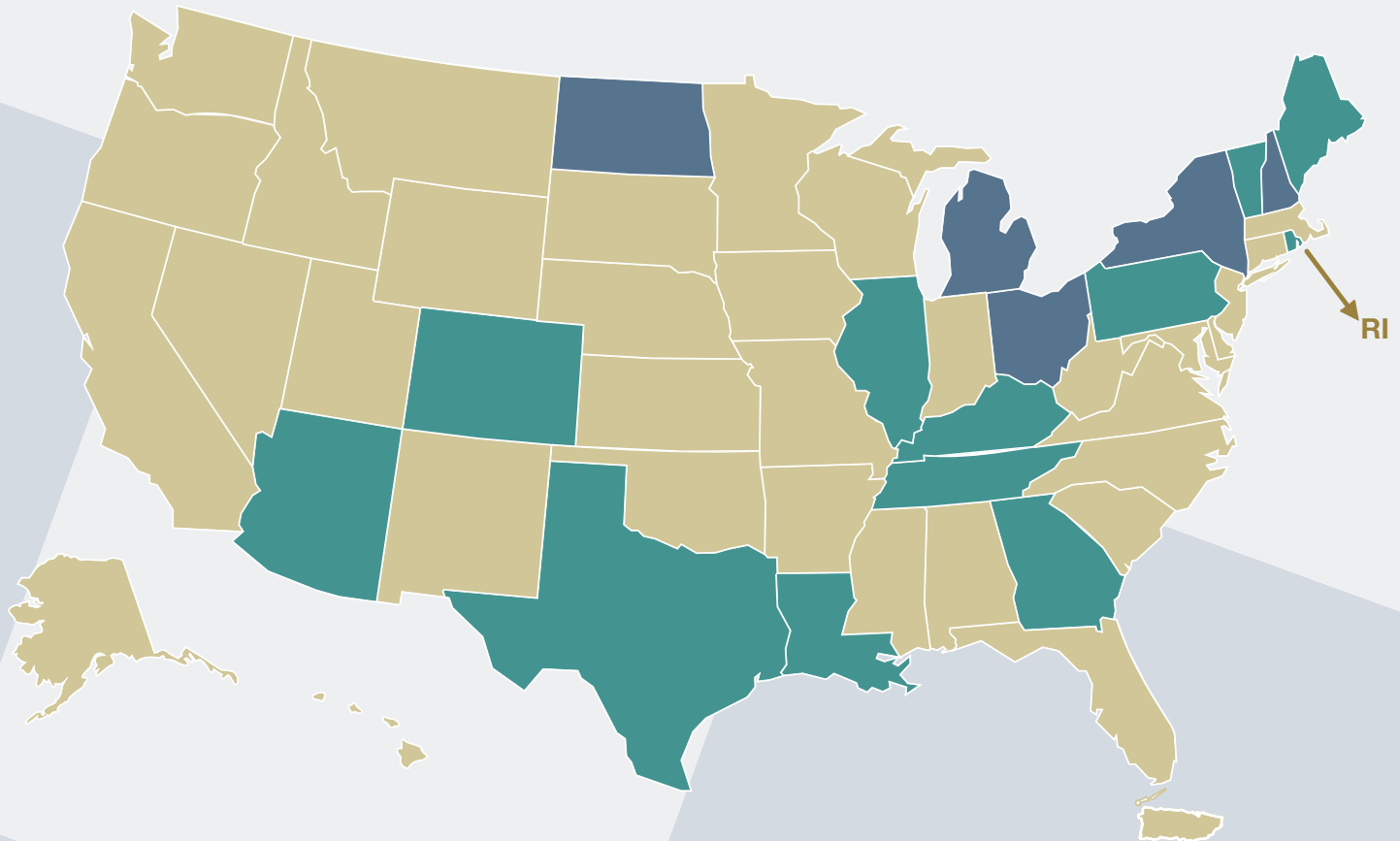
Southeastern Pennsylvania Rollout of the Chronic Care Initiative (PA)

Rhode Island Chronic Care Sustainability Initiative (CSI-RI) (RI)

Memphis Multi-Payer Patient-Centered Medical Home (TN)

Texas Patient-Centered Medical Home Demonstration Project (TX)

Patient-Centered Medical Home—Vermont (VT)



■ States with a Single Pilot Program
 ■ States with Multiple Pilot Programs

PROJECT TITLE

UnitedHealth Group PCMH Demonstration Program

PROJECT LOCATION

Arizona

Region within State

Phoenix / Tucson Metropolitan Areas

PROJECT STATUS *Under Development*

Currently processing provider applications for pilot.

Target Start Date

1/1/2009

Pilot/Demo Length

36 Months

CONVENING ENTITY/PROJECT CONTACTS

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BRIEF OVERVIEW/RESEARCH QUESTION/FOCUS OF PROJECT

The intent of the Program is to demonstrate the value of a Patient-Centered Medical Home (PCMH) primary care practice. The “home” physician will be responsible for the primary care of the individual patient as well as managing and arranging care collaboratively with United for those patients. Though the emphasis will be on primary disease prevention and improving quality of care for chronically ill patients, the Program includes an outreach to members to be more engaged in their overall health and wellness. United is committed to participate and work cooperatively with Medical Group to further these goals.

EXPECTED OR ACTUAL DEMOGRAPHICS OF PARTICIPATING PRACTICES

Number of Practices

3-6

Number of Overall Participating Physicians

20

Types of Practices

Internal Medicine, Family Medicine

Range in Number of Physicians Per Practice

Up to 10

Health Plan Lines of Business Included

Commercial, Medicare Advantage

Overall Number of Covered Lives

6000—Medicaid and inclusion of two ASO's is under consideration

MEDICAL HOME RECOGNITION PROGRAM

NCQA PPC-PCMH, UnitedHealth Group also promotes the Premium® Designation Program

PRACTICE TRANSFORMATION SUPPORT (INCLUDING TECHNOLOGY)

UnitedHealth Group will engage an industry recognized consultative vendor to assist with transformation planning, coaching, and facilitation.

PAYMENT MODEL

Monthly Care Management Fee plus performance bonus

PROJECT EVALUATION

Will use a UnitedHealthcare Economics endorsed internal measurement plan, third-party vendor for assessing transformation progress, and third-party review of overall measurement approach

Types of Data to be Collected

Clinical Quality, Cost, Patient Experience/Satisfaction, Provider Experience/Satisfaction

State-By-State Guide

Multi-stakeholder

PROJECT TITLE

Colorado Multi-Stakeholder Multi-State PCMH Pilot

Project Location

Colorado (Partner state: Ohio)

Region within State

Front Range-Colorado Springs, Denver Metro and Ft. Collins

PROJECT STATUS *Under Development*

Technical Assistance for Practices to achieve at minimum NCQA PPC-PCMH Level 1 will start by November 1, 2008.

Target Start Date

4/1/2009

Pilot/Demo Length

2 years

CONVENING ENTITY/PROJECT CONTACTS

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BRIEF OVERVIEW/RESEARCH QUESTION/FOCUS OF PROJECT

The goal of the pilot is to design and implement a Multi-Stakeholder Multi-State Patient-Centered Medical Home (PCMH) Pilot consistent with the Joint Principles of the Patient-Centered Medical Home proposed by the national professional associations representing primary care physicians. Colorado will be partnering with the Health Improvement Collaborative of Greater Cincinnati in Ohio. The pilot, while requiring a significant investment of resources, will create a significant return on this investment through creating value within the health care delivery system. The Pilot will generate knowledge on how to better sustain primary care, transform the current system of health care, and create a more cost-effective health care system. The study aims to examine take up of the medical home intervention and identify factors associated with fulfillment of the structural criteria defined by the PPC-PCMH as well as examining cost, utilization, quality and satisfaction parameters.

PARTICIPATING STAKEHOLDERS

Aetna; Anthem-Wellpoint; CIGNA; Humana; Rocky Mountain Health Plan; United Healthcare; Colorado Medicaid Program; Colorado Business Group on Health (CBGH); IBM; Patient-Centered Primary Care Collaborative (PCPCC); American Academy of Family Physicians (AAFP); American College of Physicians (ACP); Colorado Medical Society

State-By-State Guide

Multi-stakeholder

EXPECTED OR ACTUAL DEMOGRAPHICS OF PARTICIPATING PRACTICES

Number of Practices

10-15

Number of Overall Participating Physicians

Dependent on number of practices chosen

Types of Practices

Internal Medicine, Family Medicine

Range in Number of Physicians Per Practice

2-5 Providers

Health Plan Lines of Business Included

Commercial, Medicare Advantage, Medicaid Managed Care

Overall of Covered Lives

30,000

MEDICAL HOME RECOGNITION PROGRAM

NCQA PPC-PCMH

PRACTICE TRANSFORMATION SUPPORT (INCLUDING TECHNOLOGY)

Colorado Clinical Guidelines Collaborative will provide technical assistance to support pilot practices to achieve NCQA PPC-PCMH. Quality Improvement Coach (QIC) provide practice level support to help practices implement consistent and reliable processes. Methods and support tools utilized include the Chronic (Planned) Care Model, Lean Training Principles and the Model for Improvement. Learning Collaborative Sessions will supplement In-Office Coaching. This model is consistent with the framework of the National Improving Performance in Practice (IPIP) Program.

PAYMENT MODEL

Three Tiered Reimbursement Methodology consistent with the Joint Principles of Patient-Centered Medical Home: FFS, Care Management Fee which increases with higher levels of NCQA PPC-PCMH achievement
Payment begins at Level I

PROJECT EVALUATION

Meredith Rosenthal, MD, MPH, Harvard School of Public Health

Types of Data to be Collected

Clinical Quality, Cost, Patient Experience/Satisfaction, Provider Experience/Satisfaction

A Matched Comparison Group Methodology will be used to evaluate the effectiveness of PCMH qualities on cost, quality and satisfaction for both provider office and patient.

RELEVANT LINKS

<http://coloradoguidelines.org/pcmh/news.asp>

<http://coloradoguidelines.org/pcmh/articles.asp>

<http://www.coloradoafp.org/cafp/pages/patientcentered.asp>

State-By-State Guide

Insurer-based

PROJECT TITLE

Wellstar Health System

Project Location

Georgia

Region within State

Atlanta

PROJECT STATUS *Active*

Start Date

5/1/2008

Pilot/Demo Length

12 Months—initial

CONVENING ENTITY/PROJECT CONTACTS

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BRIEF OVERVIEW/RESEARCH QUESTION/FOCUS OF PROJECT

Continue to test the Medical Home model and the effect on outcomes, quality and cost for members in fully insured, ASO and Medicare product types. We will be evaluating the success of the project based upon clinical, financial and satisfaction measures.

PARTICIPATING STAKEHOLDERS

Wellstar

EXPECTED OR ACTUAL DEMOGRAPHICS OF PARTICIPATING PRACTICES

Number of Practices

2

Number of Overall Participating Physicians

13

Types of Practices

Internal Medicine, Family Medicine

Range in Number of Physicians Per Practice

5-6

Health Plan Lines of Business Included

Commercial, Other

Overall Number of Covered Lives

850

State-By-State Guide

Insurer-based

MEDICAL HOME RECOGNITION PROGRAM

NCQA PPC-PCMH, in process

PRACTICE TRANSFORMATION SUPPORT (INCLUDING TECHNOLOGY)

Gap assessment, additional reporting capabilities, etc.

PAYMENT MODEL

MPPM payment based upon potential savings

PROJECT EVALUATION

Internal

Types of Data to be Collected

Clinical Quality, Cost, Patient Experience/Satisfaction, Provider Experience/Satisfaction

RELEVANT LINKS

www.wellstar.org

State-By-State Guide

Multi-stakeholder

PROJECT TITLE

Quality Quest Medical Home

Project Location

Illinois

Region within State

Peoria and surrounding counties

PROJECT STATUS *Under Development*

Target Start Date

2/2009

Pilot/Demo Length

1 year

CONVENING ENTITY/PROJECT CONTACTS

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BRIEF OVERVIEW/RESEARCH QUESTION/FOCUS OF PROJECT

To create a Medical Home Model for the tri-county area, including the processes, tools, information and payer/employer benefit designs that facilitate the delivery of continuous, comprehensive care and managing and coordinating care necessary to implement a Medical Home Pilot. The Medical Home Model will be designed in such a way as to be readily scalable to include additional potential payers and an effort will be made to involve them.

PARTICIPATING STAKEHOLDERS

Quality Quest; OSF Healthcare; Peoria Health Department; Health Alliance; ACP; Heartland Community Clinic; Caterpillar

EXPECTED OR ACTUAL DEMOGRAPHICS OF PARTICIPATING PRACTICES

Number of Practices

3

Number of Overall Participating Physicians

TBD

Types of Practices

Undecided

Range in Number of Physicians Per Practice

TBD

State-By-State Guide

Multi-stakeholder

Health Plan Lines of Business Included

Undecided

Overall Number of Covered Lives

TBD

MEDICAL HOME RECOGNITION PROGRAM *Undecided*

PRACTICE TRANSFORMATION SUPPORT (INCLUDING TECHNOLOGY)

The current plan is to ensure that all participating practices have EMR. Transformation support in the form of process and training assistance may also be provided.

PAYMENT MODEL *Undecided*

This is currently in discussion. The team has examined a variety of models but has not settled on one yet.

PROJECT EVALUATION *Undecided*

Types of Data to be Collected

Clinical Quality, Cost, Patient Experience/Satisfaction, Provider Experience/Satisfaction

State-By-State Guide

Multi-stakeholder

PROJECT TITLE

Louisiana Health Care Quality Forum Medical Home Initiative

PROJECT LOCATION

Louisiana

Region within State

Greater New Orleans, Baton Rouge, Lake Charles, Shreveport

PROJECT STATUS *Under Development, Active*

Start Date

9/2007

Pilot/Demo Length

3 years

CONVENING ENTITY/PROJECT CONTACTS

Louisiana Health Care Quality Forum

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BRIEF OVERVIEW/RESEARCH QUESTION/FOCUS OF PROJECT

The LHCQF is a multi-stakeholder nonprofit organization whose mission is to lead evidence based quality improvement initiatives to improve the health of the people of Louisiana. The LHCQF's Medical Home Committee was formed to promote the adoption of the patient-centered medical home system of care. In January 2008, the LHCQF board adopted the Joint Principles of the Patient-Centered Medical Home and the NCQA standards. Currently the committee is focusing its efforts in 3 areas:

- 1) Serving as a learning collaborative for clinics and practices in LA who are working to meet the NCQA standards for a medical home
- 2) Working with employers through the LHCQF's Education and Outreach Committee to develop a benefits package that will support medical home provision of services through private insurance
- 3) Serving on the Department of Health and Hospitals Technical Advisory Group and monitoring and advising the Dept on development of Medicaid waiver Provider Service Networks based around medical homes

PARTICIPATING STAKEHOLDERS

Tulane University; LA Office of Group Benefits; Roy O Martin Lumber Co; Blue Cross Blue Shield of LA; LA State Medical Society; Ochnser, Medicaid; Dept. of Health and Hospitals; Louisiana Business Group on Health; Calcasieu Parish Medical Society; St. Thomas Community Health Center; St. Charles Community Health Center; LA Public Health Institute; Medical Center of LA; LSU; Homecare; Capitol Area Human Services Authority; Franciscan Missionaries of Our Lady Health Systems; LA Hospital Association; Children's Hospital Medical Practice Corporation; Baton Rouge Family Medical Center; North Caddo and LSU Medical Center; Public Affairs Research Council of Louisiana; Veteran's Administration; Maternal and Child Health Coalition; Children's Special Health Services; Healthworks; Amedisys; Franklin Medical Center

EXPECTED OR ACTUAL DEMOGRAPHICS OF PARTICIPATING PRACTICES

Number of Overall Participating Physicians:

>500

Types of Practices

Internal Medicine, Family Medicine, Pediatrics

Range in Number of Physicians per Practice

1-300

Health Plan Lines of Business Included

Medicaid Managed Care, Other

Overall Number of Covered Lives

1,200,000

MEDICAL HOME RECOGNITION PROGRAM

NCQA PPC-PCMH

PRACTICE TRANSFORMATION SUPPORT (INCLUDING TECHNOLOGY)

Medical Home Summit was held in May featuring national and local leaders as presenters. "The Patient-Centered Medical Home in Louisiana Spring 2008 Progress Report" and "Medical Home Toolkit" were published and distributed. We continue to provide educational resources to local practices through an onsite regional workshop and information sharing within a learning collaborative network. EHR adoption is being promoted through implementation of a CMS Demonstration project to provide enhanced reimbursement to 100 small to medium size practices statewide and technical support to up to 200 practices statewide. HIT Summit is scheduled for November 2008 and will include presentations geared to assist practices to move forward with using various HIT tools.

PAYMENT MODEL

Benefits package design with payment incentives to be developed

PROJECT EVALUATION *Undecided*

RELEVANT LINKS

www.lhcqf.org

State-By-State Guide

Multi-stakeholder

PROJECT TITLE

Maine Multi-Payer Patient-Centered Medical Home Pilot

Project Location

Maine

Region within State

Statewide

PROJECT STATUS *Under Development*

Target Start Date

Early 2009

Pilot/Demo Length

3 years

CONVENING ENTITY/PROJECT CONTACTS

Maine Quality Forum; Quality Counts; and Maine Health Management Coalition

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BRIEF OVERVIEW/RESEARCH QUESTION/FOCUS OF PROJECT

The Maine multi-payer pilot of the Patient-Centered Medical Home (PCMH) is proposed as the first step in achieving statewide implementation of a PCMH model. We are working with all major private payers in the state and MaineCare to develop an alternative payment model that recognizes the infrastructure and system investments needed to deliver primary care in accordance with the PCMH model and rewards practices for demonstrating high quality and efficient care. We will evaluate the pilot using a comprehensive approach that includes nationally recognized measures of quality, efficiency, and patient-centered measures of care that reflect the six aims of quality care identified by the Institute of Medicine (i.e. safe, effective, timely, efficient, equitable, and patient-centered). The ultimate goal of this effort is to sustain and revitalize primary care both to improve health outcomes for all Maine people and to reduce overall health care costs.

PARTICIPATING STAKEHOLDERS

Maine Quality Forum; Quality Counts; Maine Health Management Coalition; Anthem Blue Cross & Blue Shield; Aetna Inc.; CIGNA; Harvard Pilgrim Health Care; MaineCare; Maine Chapter American Academy Family Physicians; Maine Chapter American College of Physicians; Maine Chapter American Academy of Pediatrics; Maine Medical Association; Maine Osteopathic Association; Maine Primary Care Association; Consumers for Affordable Healthcare; Maine Association of Federally Qualified Health Centers, Indian health centers, and island-based community health centers

EXPECTED OR ACTUAL DEMOGRAPHICS OF PARTICIPATING PRACTICES

Number of Practices

10-20

Number of Overall Participating Physicians

30-50

Types of Practices

Undecided

Range in Number of Physicians Per Practice

Est. 1-5

Health Plan Lines of Business Included

Commercial, Medicaid, Managed Care

Overall Number of Covered Lives

Est. 30-50,000

MEDICAL HOME RECOGNITION PROGRAM

NCQA PPC-PCMH

Plan to first ask interested practices to complete MHIQ as self-assessment prior to submitting NCQA PPC-PCMH

PRACTICE TRANSFORMATION SUPPORT (INCLUDING TECHNOLOGY)

Planning to offer support to participating practices through participation in a PCMH learning collaborative and practice coaching

PAYMENT MODEL *Undecided*

PROJECT EVALUATION

TBD

Types of Data to be Collected

Undecided

RELEVANT LINKS

Brief summary and update are available on the Quality Counts web site at <http://www.mainequalitycounts.org/library/2008-2441804658.pdf> (summary) and <http://www.mainequalitycounts.org/article.php?IDN=10> (update)

State-By-State Guide

Multi-stakeholder

PROJECT TITLE

Aligning PCMH Stakeholders in Michigan

Project Location

Michigan

Region within State

Statewide

PROJECT STATUS *Under Development*

The Michigan Primary Care Consortium convened four PCMH Stakeholder meetings between April and October 2008 to lay groundwork for collaboration/alignment around PCMH in Michigan.

CONVENING ENTITY/PROJECT CONTACTS

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BRIEF OVERVIEW/RESEARCH QUESTION/FOCUS OF PROJECT

The Michigan Primary Care Consortium (MPCC), made up of public and private stakeholders who support the transformation of primary care delivery systems in Michigan, is convening a series of PCMH meetings. In April 08, the MPCC sponsored the Improving Performance in Practice (IPIP) program and invited multiple stakeholders to hear speakers from Colorado IPIP and Commonwealth Fund present a pilot opportunity. As a follow up, MPCC is convening a series of meetings for payers and professional associations to create a PCMH definition, metrics and practice recognition process for Michigan in order to:

1. Decrease the burden that would be imposed on practices through each payer creating a PCMH plan using different assumptions and requirements, and
2. Lay the foundation for future consideration of multi-payer pilots and/or other collaborative work.

Once the group attains consensus, the products will be widely distributed to additional stakeholders for input and consensus building.

PARTICIPATING STAKEHOLDERS

Michigan Primary Care Consortium; Primary Care Professional Associations; Insurance Companies; Health Plans

State-By-State Guide

Multi-stakeholder

EXPECTED OR ACTUAL DEMOGRAPHICS OF PARTICIPATING PRACTICES

Types of Practices

Undecided

Health Plan Lines of Business Included

Undecided

MEDICAL HOME RECOGNITION PROGRAM

NCQA PPC-PCMH, Other, Undecided

The PCMH recognition process developed by BCBSM as part of its Provider Group Incentive Program will likely be a recognition option.

PRACTICE TRANSFORMATION SUPPORT (INCLUDING TECHNOLOGY) *Undecided*

Several initiatives in Michigan are available to support practice transformation. The MPCC sponsored Improving Performance in Practice Program (IPIP) will assist practices achieve PCMH recognition through a learning collaborative experience, implementing a process improvement change package, and on-site coaching by industry trained and loaned experts in quality and process improvement. In addition to engaging 30 practices in 2008 and 100 in 2009, IPIP plans to develop local/regional support for ongoing quality and process improvement in practices.

PAYMENT MODEL *Undecided*

PROJECT EVALUATION *Undecided*

Types of Data to be Collected

Undecided

RELEVANT LINKS

www.mipcc.org

<http://ipip.aiag.org>

State-By-State Guide

PROJECT TITLE

Blue Cross Blue Shield of Michigan—Physician Group Incentive Program (PGIP)

Project Location

Michigan

Region within State

Statewide

PROJECT STATUS *Active*

Start Date

2005

Pilot/Demo Length

Mid-2010

CONVENING ENTITY/PROJECT CONTACTS

Blue Cross Blue Shield of Michigan

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BRIEF OVERVIEW/RESEARCH QUESTION/FOCUS OF PROJECT

Initial 2005 pilot to reward medical groups for infrastructure improvement to measure and improve the care of patients with four chronic illnesses. The initial pool was based on 0.5% of physician payment. Current program is for PPO. 1% of physician payment is set aside. Provider payment is based on performance, improvement, degree of physician participation, and collaborative efforts. Pilot is focused on Physician Organizations (POs) as the frame of reference because a major goal is to catalyze and facilitate the development of organization systems of care. BCBSM is using incentives, aggregated among physicians in POs, to support infrastructure development, allowing each PO, and each physician office, to build component capabilities of the PCMH model as best they see fit, given the state of their own practice at the outset. As physicians' offices reach a reasonable minimum level of capability with regard to PCMH domains of function, then BCBSM will begin to alter payment.

PARTICIPATING STAKEHOLDERS

Blue Cross Blue Shield of Michigan

EXPECTED OR ACTUAL DEMOGRAPHICS OF PARTICIPATING PRACTICES

Number of Practices

35

Number of Overall Participating Physicians

6471

Types of Practices

Internal Medicine, Family Medicine, Pediatrics, Other

State-By-State Guide

Insurer-based

Health Plan Lines of Business Included

Commercial

Overall Number of Covered Lives

1,700,000

MEDICAL HOME RECOGNITION PROGRAM

Other

Infrastructure (PCMH domains of function), Performance on Evidence-Based Care Measures, Attributed Population Use Rates (generics, ER, IP, Imaging), Patient Experience of Care (mini-CAHPS survey)

PRACTICE TRANSFORMATION SUPPORT (INCLUDING TECHNOLOGY)

Learning collaboratives for providers; Incentives to physicians that meet goals towards “initiative tasks” before functioning as a MH; Rewards for PGIP service-specific initiatives at improved results level; Rewards for New PCMH activities, then higher level of reimbursement for office-based E&M codes to physicians who are designated by BCBSM as a PC-MH

PAYMENT MODEL

BCMSMI pays T-Codes for practice-based care management, including: services by RN, dietitian, diabetes educator, MSW, clinical pharmacist, or respiratory therapist, and patients with care plan in medical record and diagnosis of persistent asthma, COPD, HF, diabetes, CAD, or major depression.

In mid-2009, BCBSMI will begin implementation of differential E&M reimbursement (10% higher) for practices that meet criteria for BCBSMI designation as a Basic PCMH.

PROJECT EVALUATION

University of Michigan—Center for Healthcare Research and Transformation

Types of Data to be Collected

Clinical Quality, Cost, Patient Experience/Satisfaction, Provider Experience/Satisfaction

Effectiveness measured by increased access to care/decreased fragmentation of care, reduced cost and use, improved health care processes and outcomes, increased satisfaction (patients/providers)

RELEVANT LINKS

http://www.bcbsm.com/provider/value_partnerships/pgip/index.shtml

PROJECT TITLE

CIGNA and Dartmouth-Hitchcock Patient-Centered Medical Home Pilot

Project Location

New Hampshire

Region within State

Multiple locations

PROJECT STATUS *Active*

Start Date

6/1/2008

Pilot/Demo Length

Ongoing

CONVENING ENTITY/PROJECT CONTACTS

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BRIEF OVERVIEW/RESEARCH QUESTION/FOCUS OF PROJECT

CIGNA and Dartmouth-Hitchcock (D-H) launched a PCMH pilot program 6/1/2008, with the goal of improving the quality, affordability and patient satisfaction with care through collaboration and aligned incentives. The program has three key components: clinical information, clinical collaboration, and a blended payment model. Along with a member roster, CIGNA provides D-H with lists of identified high risk patients according to mutually agreed upon criteria. D-H provides “embedded case management services”—i.e. a nurse who helps to coordinate the care of the patient with the goal of improving quality and reducing avoidable ER visits and hospitalizations for this high risk group & others identified. CIGNA also provides D-H with electronic feeds of “gaps in care” where identified issues such as medication compliance or needed preventive health care can be addressed at the time of the patient’s next visit. Clinical collaboration between CIGNA and D-H encourage patient access to key programs.

PARTICIPATING STAKEHOLDERS

CIGNAHealthCare; Dartmouth-Hitchcock Clinic

EXPECTED OR ACTUAL DEMOGRAPHICS OF PARTICIPATING PRACTICES

Number of Practices:

5

Number of Overall Participating Physicians

391

Types of Practices

Internal Medicine, Family Medicine , Pediatrics

Health Plan Lines of Business Included

Commercial Medicaid

Overall Number of Covered Lives

Over 17,000

State-By-State Guide

Insurer-based

MEDICAL HOME RECOGNITION PROGRAM

NCQA PPC-PCMH

NCQA application in progress. D-H is currently participating in a Centers for Medicare and Medicaid Services (CMS) Group Physician Practice demonstration project, which allows it to develop the necessary capabilities to participate in this pilot, including case management, enhanced access and information-driven care.

PRACTICE TRANSFORMATION SUPPORT (INCLUDING TECHNOLOGY)

Internally driven and in cocoordination with CIGNA provided reporting.

PAYMENT MODEL

Enhanced care coordination fee and reward for performance model

PROJECT EVALUATION

CIGNA HealthCare

Types of Data to be Collected

Clinical Quality, Cost, Patient Experience/Satisfaction

State-By-State Guide

Multi-stakeholder

PROJECT TITLE

NH Multi-Stakeholder Medical Home Pilot

Project Location

New Hampshire

Region within State

Statewide

PROJECT STATUS *Under Development*

At the point of pilot participant selection and evaluation design

Target Start Date

1/1/2009, with a payment start of 4/1/2009

Pilot/Demo Length

2 years from payment start

CONVENING ENTITY/PROJECT CONTACTS

New Hampshire Citizens Health Initiative

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Ned Helms

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(603) 862-5030

BRIEF OVERVIEW/RESEARCH QUESTION/FOCUS OF PROJECT

The NH Multi-Stakeholder Medical Home Project was initiated in January of 2008 as a joint effort of all New Hampshire carriers and representatives of the clinical, public policy and academic communities. It is an outgrowth of the Reimbursement Work Group, whose goal is to design and implement a reimbursement system that values, prescribes and rewards medical care that is tightly coordinated and of superior quality and efficiency.

Our research questions are as follows:

1. If payers and providers make the investment in patient-centered medical homes, can it create value (as defined by cost savings or higher quality of care)?
2. Will there be sufficient value created to cover costs of investment? and
3. What are the metrics that are best correlated to value creation?

Our focus is in adult, primary care, across independent, hospital-owned and FQHC settings.

PARTICIPATING STAKEHOLDERS

New Hampshire Citizens Health Initiative; New Hampshire Institute for Health Policy and Practice; Center for Medical Home Improvement; CMS; New Hampshire Medicaid; Bi-State Primary Care; Dartmouth Hitchcock Medical Center; Elliot Hospital; Dartmouth Medical School; Anthem/Wellpoint; Cigna Health Care; Harvard Pilgrim Health Care; Colorado Clinical Guidelines Collaborative

State-By-State Guide

Multi-stakeholder

EXPECTED OR ACTUAL DEMOGRAPHICS OF PARTICIPATING PRACTICES

Number of Practices

5 to 10

Number of Overall Participating Physicians

TBD

Types of Practices

Internal Medicine, Family Medicine, Other

Range in Number of Physicians Per Practice

2 to 5

Health Plan Lines of Business Included

Commercial, Other

Overall number of Covered Lives

30,000

MEDICAL HOME RECOGNITION PROGRAM

NCQA PPC-PCMH

We will require Level 1 recognition in order to participate in the pilot. We will further use the Adult Medical Home Index to assess the degree of medical homeness.

PRACTICE TRANSFORMATION SUPPORT (INCLUDING TECHNOLOGY)

Transformation support is anticipated and a model for support and ongoing collaboration through the Center for Medical Home Improvement has been developed, but not yet funded.

PAYMENT MODEL

Prospective care management fee for entire commercial, and possibly Medicaid, population. The recommendation from NHCHI is a midpoint of \$4 PMPM, tiered across NCQA levels. The FFS component includes payment for care plan oversight and traditional services. The P4P component is based on quality improvement and cost savings outcomes prescribed in evaluation design.

PROJECT EVALUATION *Undecided*

The evaluation design is still in development. We anticipate a quasi-experimental design with multivariate analysis. It will include process measures, traditional utilization management measures, preventive and AQA/NQF measures.

Types of Data to be Collected

Clinical Quality, Cost, Patient Experience/Satisfaction, Provider Experience/Satisfaction, Other

Registry/biometric data, claims utilization and cost, provider, patient and staff satisfaction and process measures related to a change in the degree of medical homeness will all be collected.

RELEVANT LINKS

www.steppingupnh.org

<http://www.steppingupnh.org/index.cfm?ID=F698B064-FA56-9CE4-D58622FEAD5F6176>

<http://www.medicalhomeimprovement.org/>

State-By-State Guide

Insurer-based

PROJECT TITLE

Patient-Centered Medical Home—Diabetes Management

Project Location

North Dakota

Region within State

Fargo (initial effort), rolling out statewide

PROJECT STATUS *Active*

Start Date

9/1/2007

Pilot/Demo Length

Ongoing, 2 year project

CONVENING ENTITY/PROJECT CONTACTS

Blue Cross Blue Shield of North Dakota

Jon Rice, MD

Jon.Rice@bcbsnd.com

(701) 282-1048

BRIEF OVERVIEW/RESEARCH QUESTION/FOCUS OF PROJECT

This is an expansion of a prior disease management project related to diabetes in 2005. The project now involves patients with diabetes, hypertension and coronary artery disease. It has expanded from one IM site to three IM sites and one FP site. The number of patients has increased from 200 to 1,100. Care is provided in a comprehensive integrated manner at these sites. Cost and quality of care information is carefully monitored. A disease management fee is allowed on an annual basis and the payer has agreed to share demonstrated savings with the provider group. Savings are anticipated, based on a decrease in ER utilization and a decrease in hospital admissions. The prior project for diabetes demonstrated \$520 PMPY savings.

PARTICIPATING STAKEHOLDERS

Blue Cross and Blue Shield of North Dakota; MeritCare Health System

EXPECTED OR ACTUAL DEMOGRAPHICS OF PARTICIPATING PRACTICES

Number of Practices

4

Number of Overall Participating Physicians

21

Types of Practices

Internal Medicine, Family Medicine

Range in Number of Physicians Per Practice

3-7

Health Plan Lines of Business Included

Commercial

Overall Number of Covered Lives:

1,100 BCBSND insured chronic disease patients in the practices

State-By-State Guide

Insurer-based

MEDICAL HOME RECOGNITION PROGRAM

Other

Practices were expected to perform the following: Review of patient history by the care team; Development of a care plan; Tracking of care needs; Educating patients on self-management techniques; and ongoing communication with the Disease Management Nurse (DMN) to ensure medication adherence, preventive testing and better self management

PRACTICE TRANSFORMATION SUPPORT (INCLUDING TECHNOLOGY)

BCBSND provided study clinic with a small grant (as part of the 2005 pilot) and agreed to share average cost savings from first year. EMR enhancements have been made.

PAYMENT MODEL

DM fee allowed on an annual basis and sharing of demonstrated cost savings.

PROJECT EVALUATION

Internal evaluation of cost and quality measures

Types of Data to be Collected

Clinical Quality, Cost, Patient Experience/Satisfaction, Provider Experience/Satisfaction

Reduce inpatient admissions; Reduce emergency department visits; Increase patient compliance with diabetes guidelines; Improve patient self-management skills; reduce future health care costs. Clinical measures included: Percentage of members with A1C blood sugar levels below 7.0; Percentage of members with LDL levels below 100 mg/dl; Percentage of members with blood pressure below 130/80mmHg; Percentage of members who were tobacco-free; Percentage of members, age 40-75, on aspirin therapy

RELEVANT LINKS

https://www.bcbsnd.com/providers/providercasts/providercast_030.html

State-By-State Guide

Insurer-based

PROJECT TITLE

MediQhome Quality Project: Patient-Centered Advanced Medical Home Quality Improvement Initiative

Project Location

North Dakota

Region within State

Will include BCBSND participating providers in the contiguous counties of MN, SD, and MT.

PROJECT STATUS *Under Development*

Target Start Date

2009

Pilot/Demo Length

3 years

CONVENING ENTITY/PROJECT CONTACTS

Blue Cross Blue Shield of North Dakota

Jon Rice, MD

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701-282-1048

BRIEF OVERVIEW/RESEARCH QUESTION/FOCUS OF PROJECT

Starts January 1, 2009; \$5.2M project; expansion of previous medical home pilot which focused on diabetes management. The project involves the deployment of a web-based patient-centered information support and decision to all primary care physicians offices across the state. Providers will be reimbursed for use of the portal. Care suites are being developed for diabetes mellitus, hypertension, coronary artery disease, asthma, ADHD, chronic heart failure, preventive cancer screening, and immunizations. Multiple clinical information points are tracked based on information primarily from the physician's records. Care opportunities are reported through the portal directly to the providers. Near-real-time reporting is done that compares the practice performance on standard quality measures between peers.

PARTICIPATING STAKEHOLDERS

Blue Cross and Blue Shield of North Dakota; Open to all participating providers; MDdatacor, Inc.

EXPECTED OR ACTUAL DEMOGRAPHICS OF PARTICIPATING PRACTICES

Number of Practices

100

Number of Overall Participating Physicians

800

Types of Practices

Internal Medicine, Family Medicine, Pediatrics, Other

Range in Number of Physicians Per Practice

2-400

State-By-State Guide

Insurer-based

Health Plan Lines of Business Included

Commercial, Other

Overall Number of Covered Lives

The project's design allows for enrollment of all patients within a medical practice. Anticipate 650,000 patients being tracked in PCMH.

40,000-60,000 chronic disease patients covered by BCBSND are expected to be enrolled. Medicare, Medicaid and other payers may be included and tracked in the web portal at no cost.

MEDICAL HOME RECOGNITION PROGRAM

Other

Practices were expected to perform the following: Supply data to the portal, use the portal for updated information about their patients and modify practices to enhance quality performance.

PRACTICE TRANSFORMATION SUPPORT (INCLUDING TECHNOLOGY)

Technology is supplied at no charge. Each provider is responsible for arranging the download of information to the tool. A series of "best practice" and "lessons learned" discussions are planned after the program starts.

PAYMENT MODEL

Care Management Fee (CMF) allowed on a six month basis.

CMF is in addition to the Fee for Service Payment System currently in force.

PROJECT EVALUATION

There will be internal evaluation of cost and quality measures. Additionally, an outside evaluation is under consideration.

Types of Data to be Collected

Clinical Quality, Cost, Patient Experience/Satisfaction, Provider Experience/Satisfaction, Other

Reduce inpatient admissions; Reduce emergency department visits; Increase patient compliance with diabetes guidelines; Improve patient self-management skills; reduce future health care costs. Clinical measures included: Percentage of members with A1C blood sugar levels below 7.0; Percentage of members with LDL levels below 100 mg/dl; Percentage of members with blood pressure below 130/80mmHg; Percentage of members who were tobacco-free; Percentage of members, aged 40-75, on aspirin therapy. Will collect and analyze all source laboratory, EMR, registry and other data.

RELEVANT LINKS

https://www.bcbsnd.com/providers/providercasts/providercast_030.html

State-By-State Guide

Insurer-based

PROJECT TITLE

CDPHP Patient-Centered Medical Home Pilot

Project Location

New York

Region within State

Albany

PROJECT STATUS *Active*

Practice redesign is underway and new payment methodology begins 1/1/2009

Start Date

5/22/2008

Pilot/Demo Length

3 years

CONVENING ENTITY/PROJECT CONTACTS

Capital District Physicians' Health Plan (CDPHP)

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BRIEF OVERVIEW/RESEARCH QUESTION/FOCUS OF PROJECT

The primary focus of the CDPHP Medical Home Pilot is to create a new primary care reimbursement methodology that is sustainable and scalable. The hypothesis we are testing is whether the aggregate savings associated with better health outcomes and lower utilization is sufficient to fund the enhanced compensation to a primary care physician, as well as provide a surplus to the plan.

PARTICIPATING STAKEHOLDERS

CDPHP; TransforMED; Community Care Physicians; P.C.; CapitalCare Medical Group

EXPECTED OR ACTUAL DEMOGRAPHICS OF PARTICIPATING PRACTICES

Number of Practices

3

Number of Overall Participating Physicians

18

Types of Practices

Internal Medicine, Family Medicine, Pediatrics

Range in Number of Physicians Per Practice

3-10

Health Plan Lines of Business Included

Commercial, Medicare Advantage; Medicaid Managed Care; Other

State-By-State Guide

Insurer-based

Overall Number of Covered Lives

35,000

CDPHP has made the decision to begin this project as a “virtual all payer” pilot and will offer bonuses for quality outcomes for all patients (commercial and government) of the pilot practices, not just CDPHP patients.

MEDICAL HOME RECOGNITION PROGRAM

NCQA PPC-PCMH

We anticipate that the NCQA PPC PCMH Level 3 designation is necessary but not sufficient and will add additional practice requirements in the future.

PRACTICE TRANSFORMATION SUPPORT (INCLUDING TECHNOLOGY)

CDPHP has partnered with TransforMED to lead our pilot practice through their transformation efforts.

PAYMENT MODEL

The pilot will be testing a new payment model that is based on a risk adjusted comprehensive payment with potential for a significant bonus.

PROJECT EVALUATION

David W. Bates, MD, MSc

Chief, Division of General Internal Medicine, Brigham and Women’s Hospital Medical Director of Clinical and Quality Analysis, Partners Healthcare

Types of Data to be Collected

Clinical Quality, Cost, Patient Experience/Satisfaction, Provider Experience/Satisfaction

RELEVANT LINKS

www.cdphp.com

PROJECT TITLE

EmblemHealth Medical Home High Value Network Project

PROJECT LOCATION

New York

Region within State

New York City and surrounding counties

PROJECT STATUS *Active*

Recruitment completed in July 2008; 38 participating practices

Start Date

2008

Pilot/Demo Length

2 years

CONVENING ENTITY/PROJECT CONTACTS

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Judith Fifield, PhD
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(860) 679-3815

BRIEF OVERVIEW/RESEARCH QUESTION/FOCUS OF PROJECT

This project seeks to determine whether the provision of enhanced payment and support for redesign and care management results in greater transformation of supported practices to medical homes and better performance on measures of quality, efficiency, and patient experience than in comparison practices.

PARTICIPATING STAKEHOLDERS

Emblem Health (formerly Group Health Inc.); Health Plan of New York

EXPECTED OR ACTUAL DEMOGRAPHICS OF PARTICIPATING PRACTICES

Number of Practices

38—randomized into experimental and control groups

Number of Overall Participating Physicians

150

Types of Practices

Internal Medicine, Family Medicine

Range in number of physicians per practice

Majority small/solo practices

Health Plan Lines of Business Included

Commercial, Medicare Advantage, Medicaid Managed Care

Overall Number of Covered Lives

20,000

State-By-State Guide

Insurer-based

MEDICAL HOME RECOGNITION PROGRAM

NCQA PPC-PCMH

PPC-PCMH and supplementary questions are used to determine medical homeness of participating practices for payment purposes; PPC-PCMH data also used for evaluation purposes.

PRACTICE TRANSFORMATION SUPPORT (INCLUDING TECHNOLOGY)

Three support components:

- 1) Data—Participating practices will receive quarterly reports on their performance on clinical quality, efficiency and patient experience measures.
- 2) Redesign support—Participating practices will receive intensive, individualized, practice redesign technical support
- 3) Care management staff support—nurse care manager support projected at .2 FTEs for each 200 HIP/GHI members in a participating practice

Up-front costs: The participating practices are not responsible for the costs of the NCQA PPC-PCMH recognition process, which is paid by evaluation grant funds from the Commonwealth Fund (see below). Use of an EMR by participating practices is not required for participation in the project, but special pricing arrangements have been made with specific EMR and hardware/infrastructure vendors.

PAYMENT MODEL

Three part payment model:

- 1) Fee-for-service
- 2) Care management payment is equal to \$2.50 PMPM for a practice that is fully functioning as a medical home with an eligible patient population of average care management need. The specific amount depends on the level of care management need the practice's population has, and the practice's medical homeness score as determined by the PPC-PCMH survey and supplementary questions.
- 3) Performance-based payment—equal at maximum to \$2.50 PMPM for each member that is identified on the practice's member list. The specific amount earned by the practice depends on practice results on performance measures relating to quality, efficiency, and patient experience.

PROJECT EVALUATION

Ethel Donaghue

Center for Translating Research into Practice and Policy at the University of Connecticut Health Center (funded by The Commonwealth Fund)

Judith Fifield, PhD

Principal Investigator of evaluation

Types of Data to be Collected

Clinical Quality, Cost, Patient Experience/Satisfaction

Clinical quality process and outcome data at the practice level using data is based on HEDIS specifications and specifications used in the CMS Physician Quality Reporting Initiative.

Efficiency data using medical claims is used to produce practice-level calculations of savings consisting of a risk-adjusted ratio of expected to actual episode costs

Patient experience data to includes measures of overall satisfaction, access, physician communication and perceived ability to self-manage.

State-By-State Guide

Multi-stakeholder

PROJECT TITLE

New York Hudson Valley p4p/Medical Home Project

Project Location

New York

Region within State

Mid-Hudson Valley (10 county region)

PROJECT STATUS *Active*

Start Date

2008

Pilot/Demo Length

5 years

CONVENING ENTITY/PROJECT CONTACTS

THINC RHIO
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John Blair
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 (845) 897-6359

BRIEF OVERVIEW/RESEARCH QUESTION/FOCUS OF PROJECT

The Hudson Valley is implementing innovative programs to potentially improve quality and reduce the cost of health care. First, THINC RHIO is facilitating diffusion of electronic health record (EHR) implementation in offices practices of the Hudson Valley.

Second, THINC RHIO is also offering a strategic approach to pay for performance (P4P) among payers and providers across the Hudson Valley that will serve as a model for New York State. The THINC P4P project brings together multiple health plans that service the Hudson Valley region. Using standardized measures agreed upon by providers and payers, the project will provide performance incentives from multiple payers to providers.

Third, an additional component of the THINC P4P project will be an added financial incentive for private practice physicians who implement and reach Level II of Physician Practice Connections-Patient-Centered Medical Home (PCMH)TM, NCQA's new national recognition system for physician practices.

PARTICIPATING STAKEHOLDERS

Aetna; CDPHP; MVP; Anthem-Wellpoint; Hudson Health Plan; United HealthCare—via Empire plan for their state employees, IBM; Hanaford; THINC (RHIO), Taconic IPA; MedAllies; MassPro; IPRO; ViPS; Transformed; Weill Cornell Medical College

State-By-State Guide

Multi-stakeholder

EXPECTED OR ACTUAL DEMOGRAPHICS OF PARTICIPATING PRACTICES

Number of Practices

100 (estimate)

Number of Overall Participating Physicians

500

Types of Practices

Internal Medicine, Family Medicine, Pediatrics

Range in Number of Physicians Per Practice

Solo to >100 physician practices, with an average of 4 physicians per practices

Health Plan Lines of Business Included

Commercial, Medicare Advantage, Medicaid Managed Care

Overall Number of Covered Lives

Approximately 1 million (74% of the commercial members in the average physicians' panel from the 6 participating health plans)

MEDICAL HOME RECOGNITION PROGRAM

NCQA PPC-PCMH

Level 2 recognition required for additional structural payment

PRACTICE TRANSFORMATION SUPPORT (INCLUDING TECHNOLOGY)

Funding from the RHIO will supplement physician EMR subscription fees to cover basic EMR costs, including software, software maintenance, implementation, training and support.

The RHIO and the physician organization will both provide funding to cover transformation services and support provided by MedAllies, MassPro, IPRO, and Transformed.

The physician organization will cover NCQA fees and will provide administrative support needed for NCQA documentation submission. The IPA has past experience in this area. In 2007, the IPA helped over 400 physicians in New York's Hudson Valley obtain NCQA-PPC recognition.

PAYMENT MODEL

Under the NYSDOH P4P grant, THINC RHIO can match health plans dollar for dollar to a total of \$1.5 million dollars. Therefore, the maximum bonus amount for the total pool of participating physicians will be \$3 million dollars.

Incentive payments will include two components to be paid at the conclusion of the pilot: (1) an outcome component based on process and outcomes measures derived from aggregated administrative data received from all health plans participating in the project (20%) and (2) a structural component determined by achieving Level 2 Medical Home recognition using the NCQA PPC-PCMH assessment tool (80%).

PROJECT EVALUATION

Weill Cornell Medical College

Types of Data to be Collected

Clinical Quality, Cost, Patient Experience/Satisfaction, Provider Experience/Satisfaction

Clinical data will be collected from EMR and chart reviews. Utilization data will be derived from aggregated claims data. Patient and provider surveys will be done throughout the evaluation.

State-By-State Guide

Multi-stakeholder

RELEVANT LINKS

THINC RHIO: <http://www.thincrhio.org/>

MedAllies: <http://www.medallies.com>

Taconic IPA: <http://www.taconicipa.com>

HEAL1: <http://thincrhio.org/HEAL1.html>

MassPro: <http://www.masspro.org/>

State-By-State Guide

Insurer-based

PROJECT TITLE

Cincinnati Medical Home Pilot Initiative

Project Location

Ohio/Kentucky

Region within State

Cincinnati/Northern Kentucky

PROJECT STATUS *Under Development*

Target Start Date

12/1/2008

Pilot/Demo Length

12 Months

CONVENING ENTITY/PROJECT CONTACTS

Humana

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BRIEF OVERVIEW/RESEARCH QUESTION/FOCUS OF PROJECT

Continue to test the Medical Home model and the effect on outcomes, quality and cost for members in fully insured, ASO and Medicare product types. We will be evaluating the success of the project based upon clinical, financial and satisfaction measures.

EXPECTED OR ACTUAL DEMOGRAPHICS OF PARTICIPATING PRACTICES

Number of Practices

4

Number of Overall Participating Physicians

15

Types of Practices

Internal Medicine, Family Medicine

Range in Number of Physicians Per Practice

3-5

Health Plan Lines of Business Included

Commercial, Medicare Advantage, Other

Overall Number of Covered Lives

5,000

State-By-State Guide

Insurer-based

MEDICAL HOME RECOGNITION PROGRAM

NCQA PPC-PCMH

PRACTICE TRANSFORMATION SUPPORT (INCLUDING TECHNOLOGY)

Gap assessment, additional reporting capabilities, etc.

PAYMENT MODEL

PMPM payment based upon potential savings

PROJECT EVALUATION

Internal

Types of Data to be Collected

Clinical Quality, Cost, Patient Experience/Satisfaction, Provider Experience/Satisfaction

State-By-State Guide

Multi-stakeholder

PROJECT TITLE

Greater Cincinnati Aligning Forces for Quality Medical Home Pilot

Project Location

Ohio/Kentucky (Partner state: Colorado)

Region within State

Greater Cincinnati

PROJECT STATUS *Under Development*

Currently in planning phase. Expected launch spring 2009.

Target Start Date

Spring 2009

Pilot/Demo Length

2 years

CONVENING ENTITY/PROJECT CONTACTS

Health Improvement Collaborative of Greater Cincinnati

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Robert Graham, MD (Chair)
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BRIEF OVERVIEW/RESEARCH QUESTION/FOCUS OF PROJECT

Evaluating the effectiveness of the PCMH

PARTICIPATING STAKEHOLDERS

Health Improvement Collaborative of Greater Cincinnati; United HealthCare; Anthem (Wellpoint); Humana; HealthBridge

EXPECTED OR ACTUAL DEMOGRAPHICS OF PARTICIPATING PRACTICES

Number of Practices

12-15

Number of Overall Participating Physicians

Unknown

Types of Practices

Internal Medicine, Family Medicine

Range in Number of Physicians Per Practice

Unknown

Health Plan Lines of Business Included

Commercial, Medicare Advantage

State-By-State Guide

Multi-stakeholder

Overall Number of Covered Lives

Approximately 30,000

MEDICAL HOME RECOGNITION PROGRAM

NCQA PPC-PCMH

PRACTICE TRANSFORMATION SUPPORT *Undecided*

PAYMENT MODEL

Fee-for-service, care management fee, and quality incentives

PROJECT EVALUATION

Currently working with a pilot in Denver to secure research expertise from Meridith Rosenthal, PhD (Harvard) with funding from the Commonwealth Fund

Types of Data to be Collected

Clinical Quality, Cost, Patient Experience/Satisfaction, Provider Experience/Satisfaction

State-By-State Guide

Multi-stakeholder

PROJECT TITLE

Southeastern Pennsylvania Rollout of the Chronic Care Initiative

Project Location

Pennsylvania

Region within State

Southeast

PROJECT STATUS *Active*

Start Date

5/2008

Pilot/Demo Length

3 years

CONVENING ENTITY/PROJECT CONTACTS

Governor's Office of Health Care Reform

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BRIEF OVERVIEW/RESEARCH QUESTION/FOCUS OF PROJECT

The Chronic Care Commission, created by Governor Rendell, crafted a strategic plan that calls for implementing the Chronic Care model, developed by Dr. Ed Wagner and the MacColl Institute, in all primary care practices across the Commonwealth. This initiative is being implemented in stages throughout regions of the state. The efforts are being led by the Governor's Office of Health Care Reform and involve strong collaboration by providers, payers and professional organizations. The initiative incorporates the Patient-Centered Medical Home standards as a validation tool that practices are transforming their care delivery to effectively manage chronically ill patients.

PARTICIPATING STAKEHOLDERS

Governor's Office of Health Care Reform; Aetna; AmeriChoice; Cigna; HealthPartners; Independence Blue Cross; Keystone Mercy; United Healthcare; Gateway Health Plan; Richard Baron, MD; University of Pennsylvania Health System; Jefferson Health System; Temple University Health System; American Board of Internal Medicine; American College of Physicians; Pennsylvania Association of Family Physicians; Improving Performance in Practice

EXPECTED OR ACTUAL DEMOGRAPHICS OF PARTICIPATING PRACTICES

Number of Practices

32

Number of Overall Participating Physicians

149

Types of Practices

Internal Medicine, Family Medicine, Pediatrics

State-By-State Guide

Multi-stakeholder

Range in Number of Physicians Per Practice

1-10

HEALTH PLAN LINES OF BUSINESS INCLUDED

Commercial, Medicare Advantage, Medicaid Managed Care, Other

Overall Number of Covered Lives

230,000

MEDICAL HOME RECOGNITION PROGRAM

NCQA PPC-PCMH

Used as validation tool showing that practices have transformed care delivery to the Chronic Care Model

PRACTICE TRANSFORMATION SUPPORT (INCLUDING TECHNOLOGY)

We have partnered with the Pennsylvania chapter of Improving Performance in Practice (IPIP) to provide Practice Coaches and a web-based patient registry to the practices.

PAYMENT MODEL

Payments are made for infrastructure needs and as incentives to achieve Levels 1,2 and 3 in the PCMH standards.

PROJECT EVALUATION

Types of Data to be Collected

Clinical Quality, Cost, Patient Experience/Satisfaction, Provider Experience/Satisfaction, Other

RELEVANT LINKS

<http://www.rxforpa.com/assets/pdfs/ChronicCareCommissionReport.pdf>

State-By-State Guide

Multi-stakeholder

PROJECT TITLE

Rhode Island Chronic Care Sustainability Initiative (CSI-RI)

Project Location

Rhode Island

Region within State

Statewide

PROJECT STATUS *Active*

Start Date

10/1/2008

Pilot/Demo Length

2 years

CONVENING ENTITY/PROJECT CONTACTS

Rhode Island Office of Health Insurance Commissioner

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Lynn Pezzullo

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(401) 528-3222

BRIEF OVERVIEW/RESEARCH QUESTION/FOCUS OF PROJECT

The CSI-RI PCMH demonstration is the result of a two-year, broad multi-stakeholder process, funded by a grant from the Center for HealthCare Strategies to the RI Office of the Health Insurance Commissioner. All Rhode Island payers except FFS Medicare are participating. In addition to existing FFS schedules, pilot sites will receive a per-member per month fee for every member of their practice, based on an attribution methodology that is standardized across commercial payers. Pilot sites will be reimbursed by the health plans for the services of a Nurse Care Manager, who will be an employee of the practice, be based in the practice and will see patients of any and all insurers. As a condition of participation, practices and care managers will receive training through the RI Department of Health and RI Quality Improvement organization. Practices will report quarterly from an EMR or electronic registry on clinical measures for diabetes, coronary artery disease and depression.

PARTICIPATING STAKEHOLDERS

BCBS-Rhode Island; United HealthCare of New England; Neighborhood Health Plan; Medicaid; RI Office of Health Insurance Commissioner; AAFP, RI chapter; ACP, RI chapter; Care New England, Coastal Medical, Inc.; Family Doctors of East Providence; Hillside Family Practice; Lifespan Physician's PSO; Lifespan Health System; Memorial Hospital of Rhode Island, Psychological Centers; RI Area Health Education Centers; RI Business Group on Health; RI Department of Health; RI Department of Human Services; RI Economic Development Corporation/Business Innovation Factory; RI Health Center Association; RI Medical Society; RI Primary Care Physicians Corporation; RI State Employees Purchasing Program; Quality Partners of Rhode Island; Thundermist Health Centers; University Medicine Foundation

State-By-State Guide

Multi-stakeholder

EXPECTED OR ACTUAL DEMOGRAPHICS OF PARTICIPATING PRACTICES

Number of Practices

5

Number of Overall Participating Physicians

28

Types of Practices

Internal Medicine, Family Medicine

Range in Number of Physicians Per Practice

3-8

Health Plan Lines of Business Included

Commercial, Medicare Advantage, Medicaid Managed Care, Other

Overall Number of Covered Lives

28,000

Medicaid PCCM also participating.

MEDICAL HOME RECOGNITION PROGRAM

NCQA PPC-PCMH

Level 1 in 6 months, Level 2 in 18 months

PRACTICE TRANSFORMATION SUPPORT

Insurers funding dedicated, on-site nurse care manager for each pilot site, who will see patients of any/all insurers. Quality Improvement Organization and Dept. of Health providing practice training and mentoring for nurse care managers.

PAYMENT MODEL

\$3 PMPM for all patients based on standardized attribution methodology, plus direct-to-practice payments for Nurse Care Manager salary and benefits.

PROJECT EVALUATION

Meredith Rosenthal, MD, MPH and Eric Schneider, MD
Harvard School of Public Health

TYPES OF DATA TO BE COLLECTED

Clinical Quality, Cost, Patient Experience/Satisfaction, Provider Experience/Satisfaction

State-By-State Guide

Multi-stakeholder

PROJECT TITLE

Memphis Multi-Payer Patient-Centered Medical Home

Project Location

Tennessee

Region within State

Memphis

PROJECT STATUS *Under Development*

Planning in process

Target Start Date

Not yet defined, possibly 1/1/2009 for one payer

CONVENING ENTITY/PROJECT CONTACTS

Memphis Business Group on Health

Christie Travis

ctravis493@aol.com

(901) 767-9585

BRIEF OVERVIEW/RESEARCH QUESTION/FOCUS OF PROJECT

To develop a multi-payer approach to the Patient-Centered Medical Home in the Memphis area. Because there is no predominant payer in most primary care practices, the multi-payer demonstration is essential to the transformation of a typical primary care practice into a Medical Home. Most primary care practices are small groups of 2-5 physicians. There is no large primary care group.

The Memphis Business Group on Health has held two summit meetings and organized discussions with employers, internal medicine physicians, family medicine physicians, nurses, and all of the major commercial insurers in the area. Support for the concept of the Medical Home has been obtained from all involved. The next step is to facilitate the advancement of contracts from the insurers and to assist in the reorganization of primary care practices to implement the principles of the Medical Home.

PARTICIPATING STAKEHOLDERS

American College of Physicians; Health Memphis Common Table; Federal Express; local hospitals; all major local insurers; University of Tennessee

EXPECTED OR ACTUAL DEMOGRAPHICS OF PARTICIPATING PRACTICES

Number of Practices

None enrolled to date

Number of Overall Participating Physicians

To be determined by insurance contracts

State-By-State Guide

Multi-stakeholder

Types of Practices

Internal Medicine, Family Medicine

Range in Number of Physicians Per Practice

2-5

Health Plan Lines of Business Included

Commercial, Medicare Advantage

Overall Number of Covered Lives

To be determined

MEDICAL HOME RECOGNITION PROGRAM

NCQA PPC-PCMH

Undetermined how increment the principles and who will pay for recognition if required

PRACTICE TRANSFORMATION SUPPORT (INCLUDING TECHNOLOGY) *Undecided*

PAYMENT MODEL *Undecided*

Discussions have included 4 components; coordination payments at PPM, fee-for-service for face-to-face visits, payments for telephone and e-mail communications to patients, and P4P payments

PROJECT EVALUATION

Undecided

Types of Data to be Collected

Clinical Quality, Cost

RELEVANT LINKS

www.memphisbusinessgroup.org

State-By-State Guide

Multi-stakeholder

PROJECT TITLE

Texas Patient-Centered Medical Home Demonstration Project

Project Location

Texas

Region within State

TBD

PROJECT STATUS *Under Development*

CONVENING ENTITY/PROJECT CONTACTS

Texas Chapter American College of Physicians
 Sue Bornstein, MD
 ssbornstein@yahoo.com
 (214) 709-7642

PARTICIPATING STAKEHOLDERS

Texas ACP; American College of Physicians, Texas Academy of Family Physicians; Texas Medical Association; Texas Medical Foundation Health Quality Institute; Texas Pediatric Society; Department of State Health Services; Aetna; BlueCross Blue Shield of Texas; CIGNA; Humana; United HealthCare; HHSC Medicaid-CHIP Division; Office of the Medical Director; IBM; HealthDialog

EXPECTED OR ACTUAL DEMOGRAPHICS OF PARTICIPATING PRACTICES

Number of Practices

Undecided

Number of Overall Participating Physicians

Undecided

Types of Practices

Undecided

MEDICAL HOME RECOGNITION PROGRAM *Undecided*

PRACTICE TRANSFORMATION SUPPORT (INCLUDING TECHNOLOGY) *Undecided*

PAYMENT MODEL *Undecided*

PROJECT EVALUATION *Undecided*

PROJECT TITLE:

Patient-Centered Medical Home—Vermont

Project Location

Vermont

Region within State

Springfield, St. Johnsbury, Rutland, Chittenden County

PROJECT STATUS *Active*

Start Date

7/1/2005

CONVENING ENTITY/PROJECT CONTACTS

Blue Cross and Blue Shield Vermont

Sharon Winn

winns@bcbsvt.com

(802) 371-3230

BRIEF OVERVIEW/RESEARCH QUESTION/FOCUS OF PROJECT

Pilot Pay for Quality Program is aligned with The Chronic Care Model and the VT Blueprint for Health. P4Q pilot program started in 2005 with diabetes and was roughly built off of the structure of the NCQA Diabetes Physician Recognition Program.

Maryland participation in the P4Q program requires the proactive adoption of practice infrastructure changes, derived from the Health System component of The Chronic Care Model.

PARTICIPATING STAKEHOLDERS

Blue Cross and Blue Shield of Vermont

Newer sites are part of Vermont's Blueprint for Health initiative, which is an integrated approach involving three commercial payers, state health benefit programs, department of health, regulator, consumers, employer groups, and providers.

EXPECTED OR ACTUAL DEMOGRAPHICS OF PARTICIPATING PRACTICES

Number of Practices

16

Number of Overall Participating Physicians

86

Types of Practices

Internal Medicine, Family Medicine, Pediatrics

Range in Number of Physicians Per Practice:

1-32

Health Plan Lines of Business Included

Commercial

Overall Number of Covered Lives

15,000

MEDICAL HOME RECOGNITION PROGRAM

Other

Aligned with Chronic Care Model and Vermont Blueprint for Health

PRACTICE TRANSFORMATION SUPPORT (INCLUDING TECHNOLOGY)

Practices may utilize some BCBSVT tools and services to satisfy program entry requirements, or use enhanced funding to support development of their own infrastructure and systems.

PAYMENT MODEL

Increased reimbursement is available for office-based E&M, consultations, preventive medicine and counseling codes. The enhanced reimbursement applies to all of the practices patients, not just those with select chronic conditions.

PROJECT EVALUATION

Evaluation is based on quality improvement at pilot sites using relevant HEDIS measures

Types of Data to be Collected

Clinical Quality, Patient Experience/Satisfaction, Provider Experience/Satisfaction

RELEVANT LINKS

<http://healthvermont.gov/blueprint.aspx#about>

JOINT PRINCIPLES OF THE PATIENT-CENTERED MEDICAL HOME

American Academy of Family Physicians (AAFP)
American Academy of Pediatrics (AAP)
American College of Physicians (ACP)
American Osteopathic Association (AOA)

INTRODUCTION

The Patient-Centered Medical Home (PCMH) is an approach to providing comprehensive primary care for children, youth and adults. The PCMH is a health care setting that facilitates partnerships between individual patients, and their personal physicians, and when appropriate, the patient's family.

The AAP, AAFP, ACP, and AOA, representing approximately 333,000 physicians, have developed the following joint principles to describe the characteristics of the PCMH.

PRINCIPLES

Personal physician—each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care.

Physician directed medical practice—the personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.

Whole person orientation—the personal physician is responsible for providing for all the patient's health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life; acute care; chronic care; preventive services; and end of life care.

Care is coordinated and/or integrated across all elements of the complex health care system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient's community (e.g., family, public and private community based services). Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.

Quality and safety are hallmarks of the medical home:

- Practices advocate for their patients to support the attainment of optimal, patient-centered outcomes that are defined by a care planning process driven by a compassionate, robust partnership between physicians, patients, and the patient's family.
- Evidence-based medicine and clinical decision-support tools guide decision making
- Physicians in the practice accept accountability for continuous quality improvement through voluntary engagement in performance measurement and improvement.
- Patients actively participate in decision making and feedback is sought to ensure patients' expectations are being met
- Information technology is utilized appropriately to support optimal patient care, performance measurement, patient education, and enhanced communication
- Practices go through a voluntary recognition process by an appropriate non-governmental entity to demonstrate that they have the capabilities to provide patient-centered services consistent with the medical home model.
- Patients and families participate in quality improvement activities at the practice level.

Joint Principles • March 2007

Enhanced access to care is available through systems such as open scheduling, expanded hours and new options for communication between patients, their personal physician, and practice staff.

Payment appropriately recognizes the added value provided to patients who have a patient-centered medical home. The payment structure should be based on the following framework:

- It should reflect the value of physician and non-physician staff patient-centered care management work that falls outside of the face-to-face visit.
- It should pay for services associated with coordination of care both within a given practice and between consultants, ancillary providers, and community resources.
- It should support adoption and use of health information technology for quality improvement;
- It should support provision of enhanced communication access such as secure e-mail and telephone consultation;
- It should recognize the value of physician work associated with remote monitoring of clinical data using technology.
- It should allow for separate fee-for-service payments for face-to-face visits. (Payments for care management services that fall outside of the face-to-face visit, as described above, should not result in a reduction in the payments for face-to-face visits).
- It should recognize case mix differences in the patient population being treated within the practice.
- It should allow physicians to share in savings from reduced hospitalizations associated with physician-guided care management in the office setting.
- It should allow for additional payments for achieving measurable and continuous quality improvements.

BACKGROUND OF THE MEDICAL HOME CONCEPT

The American Academy of Pediatrics (AAP) introduced the medical home concept in 1967, initially referring to a central location for archiving a child's medical record. In its 2002 policy statement, the AAP expanded the medical home concept to include these operational characteristics: accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective care.

The American Academy of Family Physicians (AAFP) and the American College of Physicians (ACP) have since developed their own models for improving patient care called the "medical home" (AAFP, 2004) or "advanced medical home" (ACP, 2006).

ENDORSERS

- The American Academy of Family Physicians
- The American Academy of Hospice and Palliative Medicine
- The American Academy of Neurology
- The American Academy of Pediatrics
- The American College of Cardiology
- The American College of Chest Physicians
- The American College of Osteopathic Family Physicians
- The American College of Osteopathic Internists
- The American College of Physicians
- The American Geriatrics Society

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- The American Medical Directors Association
- The American Osteopathic Association
- The American Society of Addiction Medicine
- The American Society of Clinical Oncology
- The Infectious Diseases Society of America
- The Society for Adolescent Medicine
- The Society of Critical Care Medicine
- The Society of General Internal Medicine

FOR MORE INFORMATION:

American Academy of Family Physicians
<http://www.aafp.org/pcmh>

American Academy of Pediatrics:
http://aappolicy.aappublications.org/policy_statement/index.dtl#M

American College of Physicians
http://www.acponline.org/advocacy/where_we_stand/medical_home/

American Osteopathic Association
<http://www.osteopathic.org>

Evidence on Effectiveness

EVIDENCE ON THE EFFECTIVENESS OF THE PATIENT-CENTERED MEDICAL HOME ON QUALITY AND COST

The Patient-Centered Medical Home (PCMH) is a model of health care delivery that incorporates the following characteristics associated with better outcomes and lower costs:

- **The PCMH is built upon the documented value of primary care** in achieving better health outcomes, higher patient experience, and more efficient use of resources. Patients who receive care from a **PCMH have continuous access to a personal physician who** provides comprehensive and coordinated care for the large majority of their health care needs (from Institute of Medicine definition of primary care).
- **The PCMH would be responsible for all of the patients' health care needs:** acute care, chronic care, preventive services, and end of life care working with teams of health care professionals. The PCMH would coordinate the care of its patients with specialists, lab/x-ray facilities, hospitals, home care agencies, and all other health care professionals on the patient care team.
- **The PCMH would adopt the principles of patient-centeredness:** allowing patients free choice of physician, providing prompt appointments, reducing waiting times, delivering care based on the best evidence on clinical effectiveness, empowering patients to partner with their personal physicians on decision-making, and providing care in a culturally and linguistically appropriate manner.
- **The PCMH would use health information systems** to provide data and reminder prompts such that all patients receive needed services.

According the Center for Evaluative Clinical Sciences at Dartmouth, states in the US that relied more on primary care have:

- **Lower Medicare spending** (inpatient reimbursements and Part B payments);
- **Lower resource inputs** (hospital beds, ICU beds, total physician labor, primary care labor, and medical specialist labor);
- **Lower utilization rates** (physician visits, days in ICUs, days in the hospital, and fewer patients seeing 10 or more physicians);
- **Better quality of care** (fewer ICU deaths and a higher composite quality score).¹

Additionally, according to a recent article published in the American Journal of Medicine, studying utilization rates versus primary care physician density in total physician population, **an increase from 35 to 40% PCP density serving 775,000 people could be projected to translate into:**

- 2,500 fewer inpatient admissions per year
- 15,000 fewer Emergency Room Department visits
- 2,500 fewer surgeries²

Barbara Starfield of Johns Hopkins University reviewed dozens of studies, comparing health care in the United States with other countries as well within the U.S., and found that:

- Within the United States, **adults with a primary care physician rather than a specialist had 33 percent lower costs of care and were 19 percent less likely to die**, after adjusting for demographic and health characteristics.
- **Primary care physician supply is consistently associated with improved health outcomes** for conditions like cancer, heart disease, stroke, infant mortality, low birth weight, life expectancy, and self-rated care.

Evidence on Effectiveness

- In both England and the United States, **each additional primary care physician per 10,000 persons is associated with a decrease in mortality rate** of 3 to 10 percent.
- In the United States, **an increase of just one primary care physician is associated with 1.44 fewer deaths per 10,000 persons.**
- **An orientation to primary care reduces socio-demographic and socio-economic disparities.** African Americans who have a primary care physician are less likely to die prematurely.³

A medical home can reduce or even eliminate racial and ethnic disparities in access and quality for insured persons, a new Commonwealth Fund report finds. When adults have a medical home, their access to needed care, receipt of routine preventive screenings, and management of chronic conditions improve substantially.⁴

The Fund has also found that when primary care physicians in the United States effectively manage care in the office setting, **patients with chronic diseases like diabetes, congestive heart failure, and adult asthma have fewer complications, leading to fewer avoidable hospitalizations.**⁵

A research team from RAND and the University of California at Berkeley undertook a rigorous evaluation of care provided according to PCMH principles. For almost 4,000 patients with diabetes, congestive heart failure (CHF), asthma and depression, they found that:

- Patients with **diabetes had significant reductions in cardiovascular risk;**
- **CHF patients had 35% fewer hospital days;**
- **Asthma and diabetes patients were more likely to receive appropriate therapy.**⁶

The North Carolina Medicaid program enrolls recipients in a network of physician-directed medical homes. A Mercer analysis showed that an up-front \$10.2 million investment for North Carolina Community Care operations in SFY04 saved **\$244 million in overall health care costs for the state.** Similar results were found in 2005 and 2006.⁷

The Commonwealth Fund reports that **Denmark has organized its entire health care system around patient-centered medical homes, achieving the highest patient satisfaction ratings in the world.** Primary care physicians are highly accessible and supported by an outstanding information system that assists them in coordinating care. Among Western nations, **Denmark has among the lowest per capita health expenditures and highest primary care rankings.**⁸

THE BOTTOM LINE

Care delivered by primary care physicians in a Patient-Centered Medical Home is consistently associated with better outcomes, reduced mortality, fewer preventable hospital admissions for patients with chronic diseases, lower utilization, improved patient compliance with recommended care, and lower Medicare spending.

1 Dartmouth Atlas of Health Care, Variation among States in the Management of Severe Chronic Illness, 2006

2 Kravet, Steven J. et al. Health Care Utilization and the Proportion of Primary Care Physicians. *The American Journal of Medicine*. Vol 121, No 2, February 2008. pp 142-148.

3 Starfield B. Shi L, and Macinko J., Wagner EH, Austin BT, Davis C, Hindmarsh M, Schaefer J, Bonomi A. Improving chronic illness care: translating evidence into action. *Health Aff (Millwood)*. 2001;20:64-78;ions of Primary Care to Health Systems and Health, *Millbank Quarterly*, 2005;83:457-502; Starfield, presentation to The Commonwealth Fund, Primary Care Roundtable: Strengthening Adult Primary Care: Models and Policy Options, October 3, 2006

4 A. C. Beal, M. M. Doty, S. E. Hernandez, K. K. Shea, and K. Davis, *Closing the Divide: How Medical Homes Promote Equity in Health Care: Results From The Commonwealth Fund 2006 Health Care Quality Survey*, The Commonwealth Fund, June 2007

Evidence on Effectiveness

5 Commonwealth Fund, *Chartbook on Medicare*, 2006;

6 A Robert Wood Johnson-funded evaluation of the effectiveness of the Chronic Care Model and the IHI Breakthrough Series Collaborative in improving clinical outcomes and patient satisfaction with care, accessed June 19, 2007 at <http://www.rand.org/health/projects/icing/index.html>; Higashi, Takahiro, Wenger, Neil S., Adams, John L., Fung, Constance, Roland, Martin, McGlynn, Elizabeth A., Reeves, David, Asch, Steven M., Kerr, Eve A., Shekelle, Paul G. *Relationship between Number of Medical Conditions and Quality of Care* *N Engl J Med* 2007 356: 2496-2504

7 Mercer Cost Effectiveness Analysis – AFDC only for Inpatient, Outpatient, ED, Physician Services, Pharmacy, Administrative Costs, Other). From presentation by Dobson, Al, *Patient-Centered Primary Care Roundtable*, March 12, 2007. Accessed June 24, 2007 at www.patientcenteredprimarycare.org/Meetings/March%202007/March.html

8 K. Davis, *Learning From High Performance Health Systems Around the Globe*, Invited Testimony: Senate Health, Education, Labor, and Pensions Committee Hearing “Health Care for All Americans: Challenges and Opportunities,” January 10, 2007

NCQA Scoring Criteria



PPC-PCMH CONTENT AND SCORING

Standard 1: Access and Communication		Pts	Standard 5: Electronic Prescribing		Pts
A. Has written standards for patient access and patient communication**		4	A. Uses electronic system to write prescriptions		3
B. Uses data to show it meets its standards for patient access and communication**		5	B. Has electronic prescription writer with safety checks		3
		9	C. Has electronic prescription writer with cost checks		2
					8
Standard 2: Patient Tracking and Registry Functions		Pts	Standard 6: Test Tracking		Pts
A. Uses data system for basic patient information (mostly non-clinical data)		2	A. Tracks tests and identifies abnormal results systematically**		7
B. Has clinical data system with clinical data in searchable data fields		3	B. Uses electronic systems to order and retrieve tests and flag duplicate tests		6
C. Uses the clinical data system		3			13
D. Uses paper or electronic-based charting tools to organize clinical information**		6	Standard 7: Referral Tracking		Pts
E. Uses data to identify important diagnoses and conditions in practice**		4	A. Tracks referrals using paper-based or electronic system**		4
F. Generates lists of patients and reminds patients and clinicians of services needed (population management)		3			4
		21	Standard 8: Performance Reporting and Improvement		Pts
Standard 3: Care Management		Pts	A. Measures clinical and/or service performance by physician or across the practice**		3
A. Adopts and implements evidence-based guidelines for three conditions**		3	B. Survey of patients' care experience		3
B. Generates reminders about preventive services for clinicians		4	C. Reports performance across the practice or by physician**		3
C. Uses non-physician staff to manage patient care		3	D. Sets goals and takes action to improve performance		3
D. Conducts care management, including care plans, assessing progress, addressing barriers		5	E. Produces reports using standardized measures		2
E. Coordinates care//follow-up for patients who receive care in inpatient and outpatient facilities		5	F. Transmits reports with standardized measures electronically to external entities		1
		20			15
Standard 4: Patient Self-Management Support		Pts	Standard 9: Advanced Electronic Communications		Pts
A. Assesses language preference and other communication barriers		2	A. Availability of Interactive Website		1
B. Actively supports patient self-management**		4	B. Electronic Patient Identification		2
		6	C. Electronic Care Management Support		1
					4

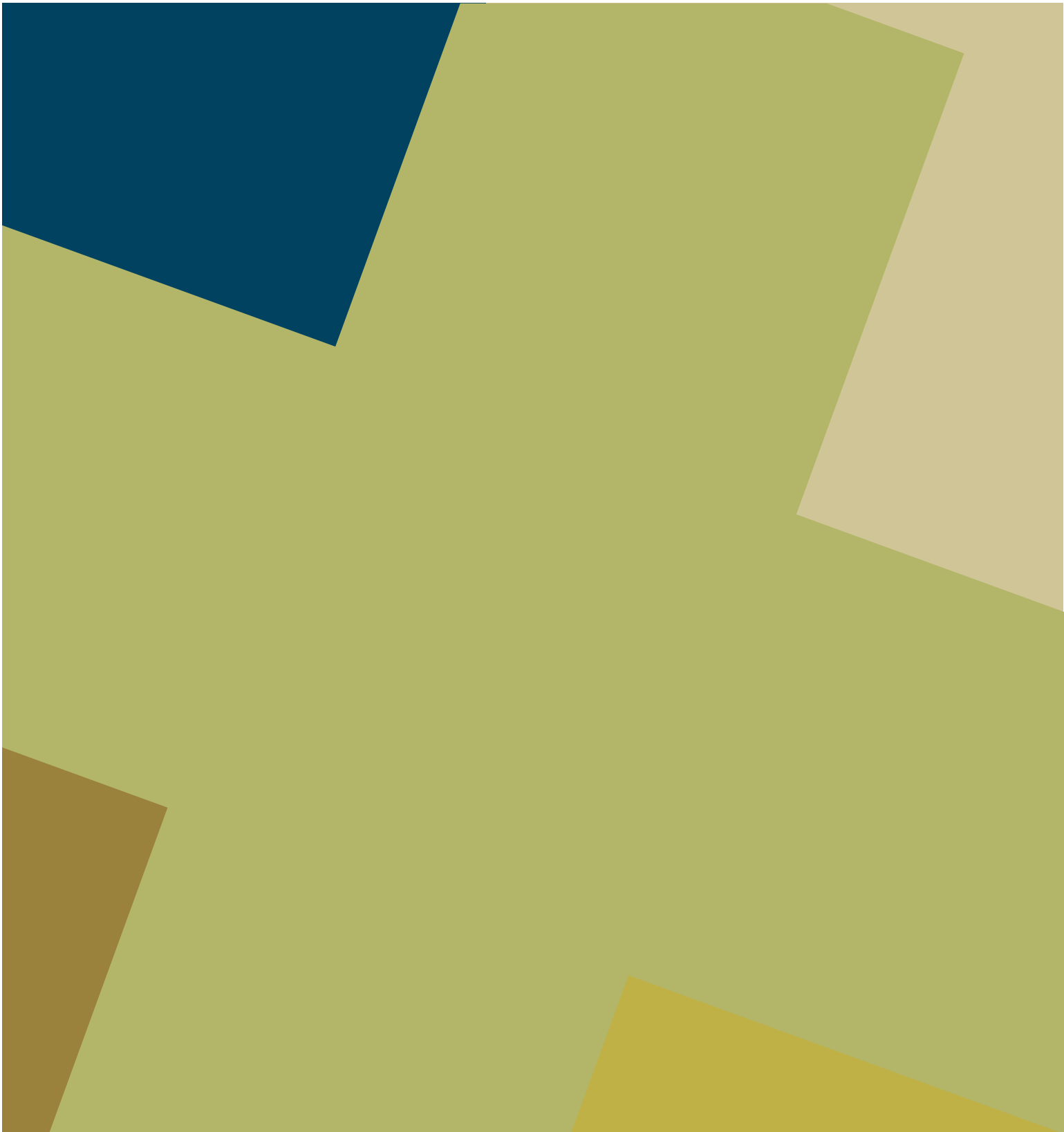
**Must Pass Elements

PPC-PCMH SCORING

Level of Qualifying	Points	Must Pass Elements at 50% Performance Level
Level 3	75 -100	10 of 10
Level 2	50 -74	10 of 10
Level 1	25 -49	5 of 10
Not Recognized	0 -24	< 5

Levels: If there is a difference in Level achieved between the number of points and "Must Pass", the practice will be awarded the lesser level; for example, if a practice has 65 points but passes only 7 "Must Pass" Elements, the practice will achieve at Level 1.

Practices with a numeric score of 0 to 24 points or less than 5 "Must Pass" Elements do not Qualify.



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