

Strategies to Better Support Team-Based in PCMH Initiatives

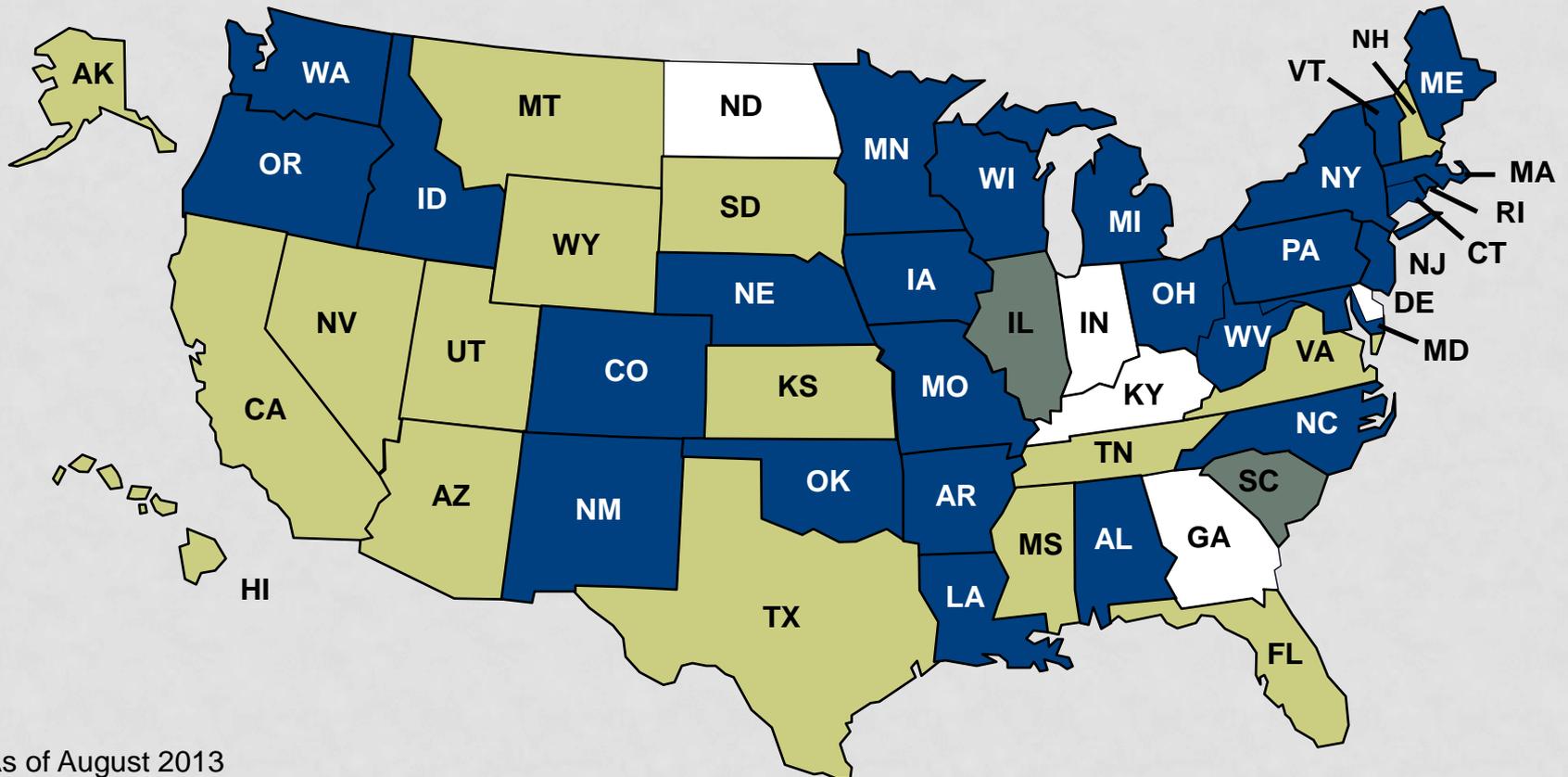
MARY TAKACH, MPH, RN
MONTANA PCMH STAKEHOLDER COUNCIL
HELENA, MONTANA, APRIL 16, 2013

NATIONAL ACADEMY
for STATE HEALTH POLICY

NASHP

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

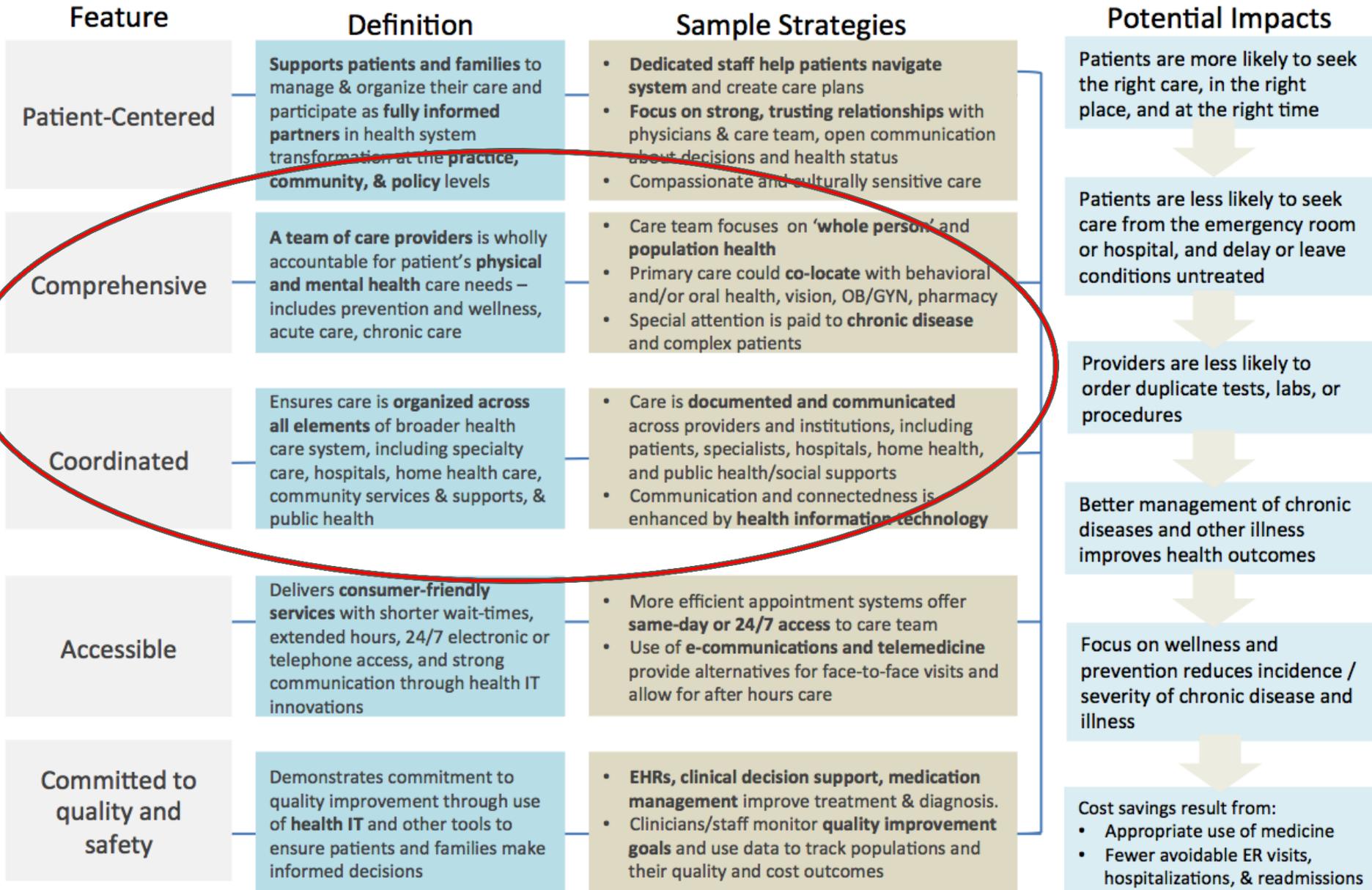
STATE-BASED MEDICAL HOME INITIATIVES



As of August 2013

-  Medical home activity (45 states and Washington, D.C.)
-  Making medical home payments (29 states)
-  Payments based on provider qualification standards (27 states)

Why the Medical Home Works: A Framework



Comprehensive

A **team of care providers** is wholly accountable for patient's **physical and mental health** care needs – includes prevention and wellness, acute care, chronic care

- Care team focuses on **'whole person'** and **population health**
- Primary care could **co-locate** with behavioral and/or oral health, vision, OB/GYN, pharmacy
- Special attention is paid to **chronic disease** and complex patients

Coordinated

Ensures care is **organized across all elements** of broader health care system, including specialty care, hospitals, home health care, community services & supports, & public health

- Care is **documented and communicated** across providers and institutions, including patients, specialists, hospitals, home health, and public health/social supports
- Communication and connectedness is enhanced by **health information technology**

EXPANDING MEDICAL HOME CAPACITY THROUGH MULTI-DISCIPLINARY TEAMS



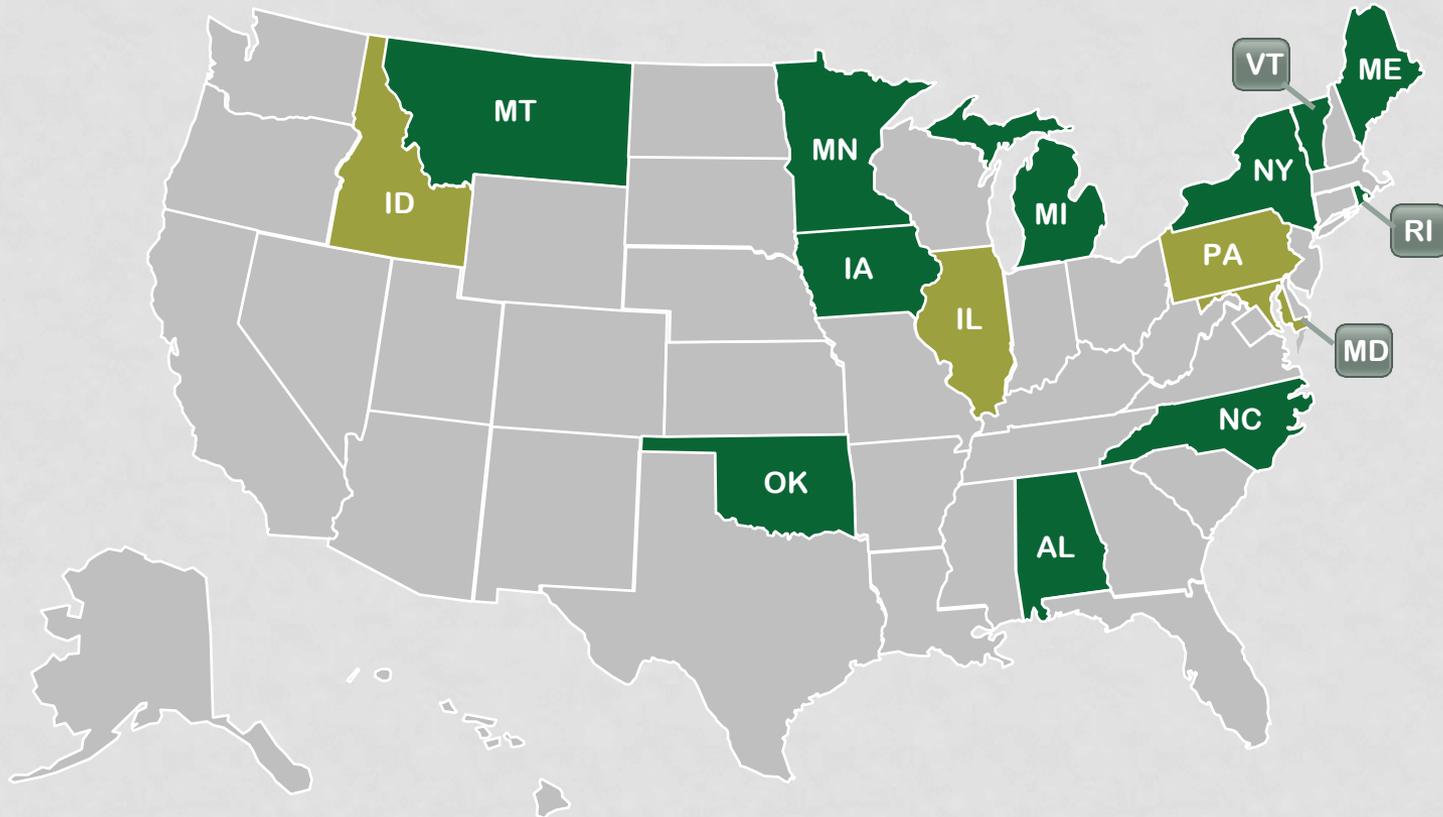
Key model features:

- Practice teams—often shared among practices
- Payments to teams and qualified providers
- Teams are based in a variety of settings
- Community developed, teams vary from region to region

WHOSE ON THE TEAM?

- New or Expanded Roles for:
 - Nurses
 - Behavioral Health Specialists
 - Community Health Workers
 - Social Workers
 - Peer Specialists
 - Pharmacists
 - Health Coaches

SHARED SUPPORT TEAMS



 Making Payments to Shared Support Teams

 Pursuing similar models through State Innovation Model Grants

SHARED COMMUNITY CARE TEAM SNAPSHOT

	Scope	Payer(s)	Payment Strategy	Core Team Composition
Alabama: Patient Care Networks of Alabama	4 networks, 170,000 eligible patients.	Medicaid (Health Home SPA)	Networks receive \$9.50 PMPM for each Health Home patient	Must include clinical director or medical director, clinical pharmacist, chronic care clinical champion (nurse), care managers (nurse or social worker)
Maine: Community Care Teams	10 care teams, 130,000 eligible patients.	Medicaid (Health Home SPA), Medicare, private plans, some self-insured employers including state employees.	Teams receive \$129.50 PMPM for Medicaid Health Homes; \$2.95 Medicaid non Health Home; \$2.95 PMPM for Medicare; \$0.30 PMPM for privately insured.	Must include part-time clinical leader; team composition based on each entity's care management strategy
Vermont: Community Health Teams	14 teams; 514,000 eligible patients.	Medicaid, Medicare, private plans, some self-insured.	Teams receive \$350,000 for 5 FTE team; costs divided proportionately among payers	Staffing structures are flexible; most include nurse care managers, behavioral health specialists/social workers, health coaches, panel managers, and tobacco cessation counselors
New York: Adirondack Region Medical Home Pilot Pods	3 pods, 106,000 eligible patients.	Medicaid, Medicare, private plans, some self-insured employers including state employees.	Pods receive \$7 PMPM payment to providers who contract with pods for support services. Average payment to pod approximately \$3.50 PMPM.	No specific staffing requirements; structures vary across pods.

PATIENT CARE NETWORKS OF ALABAMA



- Four new 501 (c)(3) organizations
- Support Patient 1st Medicaid providers
- Focus on high risk, high acuity patients
- Providers who partner with networks receive \$1.60 - \$2.10 PMPM + \$1 PMPM from Patient 1st
- Total PMPM rate for Patient 1st patients in network areas decreased by 7.7% vs. 0.6% for the rest of the state, after 1st 6 months
 - 3 network areas had a 15% decrease in their ER Use vs. non-network areas that had a 2 % during same time
(http://medicaid.alabama.gov/news_detail.aspx?ID=6608)

MAINE COMMUNITY CARE TEAMS



- Multi-payer support: PMPM varies by payer
- Community care teams based in wide variety of organizations
- Support providers meeting “NCQA Plus” including:
 - Behavioral health integration
 - Population risk-stratification and management
 - Team-based care
 - Connection to community resources
- Focus on High Costs utilizers aka “Super Utilizers”
- No outcome data available

VERMONT BLUEPRINT FOR HEALTH: COMMUNITY HEALTH TEAMS



- Statewide, multi-payer support,
- Provider reimbursement tied to NCQA PCMH recognition and CHTs help practices meet NCQA PCMH recognition
- CHTs focus on public health helping patients engage in preventive services and adopt healthier lifestyles
- Specialized care coordinators added to teams to care for elderly patients and substance abusers added
- 2013 Vermont Annual Report found that people cared for in PCMH + CHT setting had favorable outcomes vs. comparison groups including reductions in annual expenditures, more than offsetting payer investments in PCMHs and CHTs

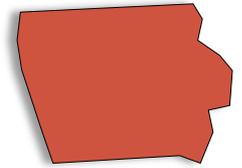
ADIRONDACKS REGIONAL PODS



- Three “pods” in upstate NY supported by a central entity (Adirondack Health Institute)
 - Regional, Multi-payer support
- Workforce shortages was primary reason for development of PCMH initiative
- Support affiliated practices and smaller independent practices in region
- PMPM reimbursement passed through by providers
- From 2006 to 2007 the region lost 24 PCPs. Since the pilot began, primary care has stabilized and grown; total costs of care has been trending downward for commercial payers and Medicaid

(<http://www.adkmedicalhome.org/wp-content/uploads/2013/10/Dennis-Weaver-Medical-Home-Summit-Presentation.pdf>)

IOWA “COMMUNITY CARE COORDINATION TEAMS”



- Pilot launched two regional teams in January 2014
- Funded by Iowa Legislature through the state’s Primary Care Association; \$300,000/team until June 2014
- Purpose is to support safety net providers and small practices
- Teams will support primary care practices in serving high-needs patients
 - Care management
 - Patient education
 - Pharmacy management
 - Behavioral health management
 - Link to community resources
- Focus on population health and social determinants
- Team composition based on community needs and resources

KEY TAKEAWAYS

- Team-based care is a key feature of a medical home
- Meeting medical home criteria, including team-based care, is hard work for practices—particularly small & rural practices
- Shared community-based support teams offer providers of all types the opportunity to participate in value-based health care delivery models
- Community-based teams can extend their reach by leveraging social, public health and other services and extend their reach
- Community based teams provide infrastructure for ACOs

For More Information

Home | About NASHP | Newsroom | E-News signup | Employment | Contact Us

NATIONAL ACADEMY
for STATE HEALTH POLICY

Search

TOPICS

- ACA Implementation & State Health Reform
- Coverage and Access
- Federal/State Issues
- Medicaid and CHIP
- Population and Public Health
- Providers and Services
- Quality, Cost, and Health System Performance
- Specific Populations

PROGRAMS

- ABCD Resource Center
- Access and the Safety Net
- Behavioral Health
- Evidence-Based Practices & Medicaid
- Children's Health Insurance
- Maximizing Enrollment
- Medical Home & Patient-Centered Care**

TOOLS & RESOURCES

- Children's Coverage Toolbox
- Multi-Payer Resource Center
- State Accountable Care Activity Map
- Patient Safety Toolbox

QUICK LINKS

- NASHP Projects & Programs
- NASHP Publications by Date
- NASHP Authors' Publications
- NASHP Publications by

Medical Home & Patient-Centered Care

Click Here for Interactive Map

Best viewed in Internet Explorer, Safari, or Chrome

A medical home is an enhanced model of primary care that provides whole person, accessible, comprehensive, ongoing and coordinated patient-centered care. First advanced by the American Academy of Pediatrics in the 1960's, the concept gained momentum in 2007 when four major physician groups agreed to a common view of the patient-centered medical home (PCMH) model defined by seven "Joint Principles." (For more information on the "Joint Principles" please go to www.pcpcc.net.) Since 2007, NASHP has been tracking and supporting state efforts to advance medical homes for Medicaid and CHIP participants. NASHP's medical home map allows you to click on a state to learn about its efforts. Our work is supported by The Commonwealth Fund.

As of April 2013, 43 states have adopted policies and programs to advance medical homes. Medical home activity must meet the following criteria for inclusion on this map: (1) program implementation (or major expansion or improvement) in 2006 or later; (2) Medicaid or CHIP agency participation (not necessarily leadership); (3) explicitly intended to advance medical homes for Medicaid or CHIP participants; and (4) evidence of commitment, such as workgroups, legislation, executive orders, or dedicated staff.

MEDICAL HOME STRATEGIES

- Forming Partnerships
- Defining and Recognizing Medical Homes
- Aligning Reimbursement & Purchasing
- Supporting Practices
- Measuring Results

MEDICAL HOMES PUBLICATIONS

- Five Key Strategies to Engage Health Care Payers and Purchasers in a Multi-Payer Medical Home Initiative
September 2013
- Issue Brief: State Strategies to Avoid Antitrust Concerns in Multipayer Medical Home Initiatives
July 2013
- Care Management for Medicaid Enrollees Through Community Health Teams
June 2013

MEDICAL HOME STATES

Please visit:

- www.nashp.org
- www.nashp.org/medical-home-map
- www.nashp.org/state-accountable-care-activity-map
- www.statereform.org

Contact:

mtakach@nashp.org
bwirth@nashp.org