



Proof in **Practice**

*A compilation of patient centered medical
home pilot and demonstration projects*

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Acknowledgments

This report was developed by the Patient-Centered Primary Care Collaborative (PCPCC) through work done by the Center for Multi-Stakeholder Demonstration. We would like to acknowledge and thank the Co-Chairs of the Center for Multi-Stakeholder Demonstration for their tireless efforts in compiling this report:

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We would also like to thank the contributors from each project, as well as the following individuals for their significant efforts in helping to produce this report:

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Primary Care: A National Conversation

In recent months Americans have witnessed a national conversation—and at times a heated debate—about reforming health care. Americans want more affordable care, but we don't want to sacrifice access to excellent care from trusted providers in order to achieve lower costs.

While the conversation has become louder, it is by no means new. Two decades of rapidly rising health care costs, with no corresponding increase in health care quality, have squeezed employers who provide health insurance coverage and directly impacted employees struggling to finance mounting out-of-pocket costs. Dissatisfaction with fragmented, uncoordinated care was amplified as reports by the Institute of Medicine publicized the gaps in patient safety in the current delivery system.¹

Today's public reform conversation focuses on providing coverage for the uninsured. But the winds of reform have also brought to light innovative practice models. Simply providing coverage for all won't solve the cost, access and quality issues that plague today's system of care. New models hold the promise not only to lower costs, but also to improve patient care and enhance both provider and patient satisfaction. The patient centered medical home (PCMH) has emerged as a comprehensive delivery model that works on both regional and state levels to rein in costs, coordinate care and improve satisfaction and outcomes.

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 PCMH. The PCPCC is dedicated to the advancement of the Joint Principles of the Medical Home, which were originally crafted by the four major

primary care medical provider associations (the American Academy of Family Physicians, the American College of Physicians, the American Academy of Pediatrics, and the American Osteopathic Association). The PCMH connects patients to a primary care team that will provide continuous and coordinated care, helping them navigate the health care system. Patients who are engaged with their providers can become full-fledged partners in their care.

New movement on the national front shows promise for rapidly expanding the public-private PCMH landscape using the Joint Principles. At a Sept. 16, 2009 announcement at the White House, Department of Health and Human Services Secretary Kathleen Sebelius and Vermont Governor Jim Douglas announced the groundbreaking Medicare-Medicaid Advanced Primary Care Demonstration Initiative. In this rollout, the term "Advanced Primary Care" (APC) refers to the PCMH, which is emerging as a leading model for efficient management and delivery of quality care. Based on the demonstration project now underway in Vermont, the federal initiative enables private insurers to work in cooperation with Medicaid to set uniform standards for APC models.

Policymakers on the national stage also recognize the need for "accountable care," a term that encompasses a vision for greater value than the current system delivers. Discussion is currently underway to fit the PCMH into the support structure that can be achieved through Accountable Care Organizations (ACOs). An ACO is a provider-led entity that is willing to manage the full continuum of care and be accountable for the overall costs and quality of care for a defined population. Like the PCMH, ACOs bring accountable care into the trusted relationship patients have with their primary care providers. The PCMH and the ACO can work as extensions of one another to enable delivery system transformation—reducing the growth

¹Crossing the Quality Chasm: A New Health System for the 21st Century (2001). Institute of Medicine (IOM).

of the cost of health care while improving quality. Built on the foundation of the PCMH, ACOs can provide the essential delivery system infrastructure beyond primary care practice to fully realize the PCMH model.

The PCPCC has moved beyond the status of a consensus group to become an advocacy force advancing the PCMH through a collaboration of like-minded stakeholders driving our shared vision of a transformed system. This report is produced as a resource document developed by the PCPCC's Center for Multi-Stakeholder Demonstrations, which has set a goal to share lessons learned and best practices from existing PCMH demonstrations. Like its predecessor published last year, the 2009 *Pilot Guide* outlines ongoing efforts around the country to build an evidence base to prove that the systems we propose as part of the PCMH model, outlined in the Joint Principles, lead to cost savings, better health outcomes and higher patient satisfaction. In the coming weeks and months, ongoing, updated and expanded data about the projects listed here, as well as data collected from other pilot sites, will become available via a supplementary online resource through the PCPCC Web site, www.pcpcc.net.

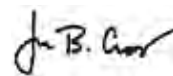
Publication of the original *Pilot Guide* successfully disseminated the nuts and bolts of the initiatives it featured, some mature and some still developing. Because testing of the efficacy of the PCMH model is still in its infancy, we are pleased that so many pilots include data collection and measurement criteria in their design so that future programs can learn from their efforts. The state-by-state reports included in this edition are drawn from two surveys designed to gather the latest information about the structure and design of programs, but they also bring in new information about evaluation, data collection and consumer engagement efforts.

In addition to the state-by-state results, this Guide includes *A Review of the Evidence on Quality, Access and Costs from Recent Prospective Evaluation Studies*, a document compiling proof of the model's promise across a number of initiatives. In addition, the outcomes for four PCMH practices were featured in the September-October 2009 Health Affairs. "American Medical Home Runs" spotlighted pilot sites that have demonstrated a minimum

15 to 20 percent cost reduction in total health care spending for patients per year than patients treated by their regional peers (Milstein, A. and Gilbertson, E., "American Medical Home Runs," *Health Aff (Millwood)*. 2009;28(5): 1317–26; 10.1377/hlthaff.28.5.1317).

It is important to note that the list of pilots included in this Guide 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 PCMH. Much work on that front is being accomplished 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 our message resonates just as strongly with public purchasers of care as it does in the private sector.

The PCPCC is truly a multi-player, collaborative effort involving all health care stakeholders. Our hope is that this document will not only serve as an informational resource, but also the impetus for those interested in the model to become involved in demonstrating its proof in practice.



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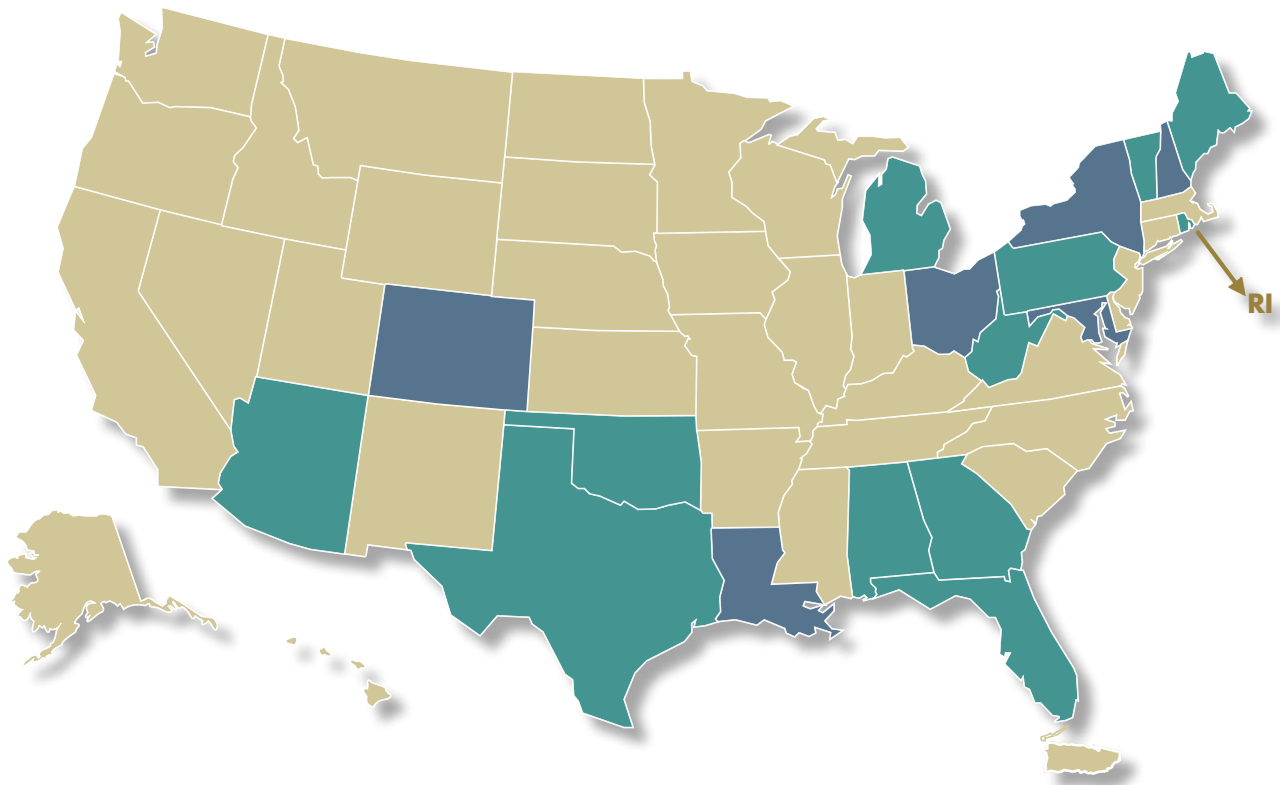


Edwina Rogers

Executive Director, Patient-Centered Primary Care Collaborative

PCMH Pilot Map

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



- Alabama Health Improvement Initiative—Medical Home Pilot (AL)
- UnitedHealth Group PCMH Demonstration Program (AZ)
- The Colorado Multi-Payer, Multi-State Patient-Centered Medical Home Pilot (CO)
- Colorado Family Medicine Residency PCMH Project (CO)
- MetCare of Florida/Humana Patient-Centered Medical Home (FL)
- WellStar Health System/Humana Patient-Centered Medical Home (GA)
- Greater New Orleans Primary Care Access and Stabilization Grant (PCASG) (LA)
- Louisiana Health Care Quality Forum Medical Home Initiative (LA)
- Maine Patient-Centered Medical Home Pilot (ME)
- CareFirst BlueCross BlueShield Patient-Centered Medical Home Demonstration Program (MD)
- National Naval Medical Center Medical Home Program (MD)
- Blue Cross Blue Shield of Michigan—Physician Group Incentive Program (PGIP) (MI)
- Priority Health PCMH Grant Program (MI)
- CIGNA and Dartmouth-Hitchcock Patient-Centered Medical Home Pilot (NH)
- NH Multi-Stakeholder Medical Home Pilot (NH)
- Hudson Valley P4P-Medical Home Project (NY)
- EmblemHealth Medical Home High Value Network Project (NY)
- Greater Cincinnati Aligning Forces for Quality Medical Home Pilot (OH)
- Queen City Physicians/Humana Patient-Centered Medical Home (OH)
- TriHealth Physician Practices/Humana Patient-Centered Medical Home (OH)
- OU School of Community Medicine—Patient-Centered Medical Home Project (OK)
- Texas Medical Home Initiative (TX)
- Vermont Blueprint Integrated Pilot Program (VT)
- West Virginia Medical Home Pilot (WV)
- Rhode Island Chronic Care Sustainability Initiative (RI)

▲ ALABAMA

Alabama Health Improvement Initiative—Medical Home Pilot

Project Title: Alabama Health Improvement Initiative—Medical Home Pilot
PROJECT LOCATION: Alabama
REGION WITHIN STATE: Statewide

Project Status: Active
TARGET START DATE: 09/01/2009
PILOT/DEMO LENGTH: 2-3 years

Convening Entity/Project Contacts

CONVENING ORGANIZATION NAME:
Blue Cross Blue Shield-Alabama
CONTACT NAME: Daniel Jackson
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Brief Overview

To analyze the medical home concept and to trend both process of care and patient outcome data over an 18 to 24 month period. At the conclusion of the pilot we hope to better understand the time and monetary efforts required by a practice to attain and maintain a medical home environment as well as be able to produce tangible data in favor of the medical home approach to care. The pilot includes both pilot and control groups.

Participating Organizations

Alabama Chapter of American Academy of Family Physicians, Alabama Chapter of American Academy of Pediatrics, Alabama Chapter of American College of Physicians.

How have you involved the consumer in the development and implementation of your demonstration?

COMMENTS: We will utilize consumer focus groups in the creation and display of patient experience-type information. Specifically, information will be requested regarding perceived quality of care, access issues encountered, and overall satisfaction. The pilot will work with pilot facilities and customers to develop the survey tool that will be used during the pilot. Patients are involved in the pilot as advocates and focus group participants. In addition, we have had conversations with both employer groups and consumer advocate organizations.

Expected or Actual Demographics of Participating Practices

OF PRACTICES: 14

NUMBER OF OVERALL PARTICIPATING PHYSICIANS: Approximately 70

RANGE OF NUMBER OF PHYSICIANS PER PRACTICE: 1-8

TYPES OF PRACTICES:

Internal Medicine
Family Medicine
Pediatrics

HEALTH PLAN LINES OF BUSINESS INCLUDED:

Commercial
Medicare Advantage

OTHER: Due to the manageable size of our pilot, we would expect any members and nonmembers seeking care at the pilot facilities to receive benefit.

OVERALL NUMBER OF COVERED LIVES: NA

Medical Home Recognition Program:

NCQA PPC-PCMH

COMMENTS: In addition to the NCQA PPC-PCMH program, we have added additional physician and practice requirements.

Practice Transformation Support (Including Technology)

Yes

FOCAL AREAS OF TRANSFORMATION:

We will provide some monetary assistance at the onset that can be used at the practices' discretion as they begin the transformation process. We will also look to serve as facilitator and intermediary throughout the pilot. Therefore the transformational activity will be both internally led by clinics and facilitated by the pilot.

Project Evaluation

We will evaluate pilot facilities on a number of agreed upon success measures focusing on increased efficiency, increased quality of care, and decreased health care cost. Information will be collected from patients, providers, clinic staff, clinical data and billing data.

EVALUATOR ORGANIZATION: Internal Evaluation- Blue Cross Blue Shield-Alabama

TYPES OF DATA TO BE COLLECTED:

Clinical Quality

Cost/Efficiency

Patient Experience/Satisfaction

Provider Experience/Satisfaction

▲ = Number of reported pilot/demonstration projects

ARIZONA

UnitedHealth Group PCMH Demonstration Program

Project Title: UnitedHealth Group
PCMH Demonstration Program
PROJECT LOCATION: Arizona
REGION WITHIN STATE: Phoenix, Tucson

Project Status: Active
TARGET START DATE: 04/01/2009
PILOT/DEMO LENGTH: 2-3 years

Convening Entity/Project Contacts
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Brief Overview

The intent of the program is to demonstrate the value of a PCMH primary care practice. The “medical 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 become more engaged in their overall health and wellness. United is committed to participate and work cooperatively with the medical group in furtherance of these goals.

Participating Organizations

IBM, other self-insured employers.

How have you involved the consumer in the development and implementation of your demonstration?

Consumer focus groups and employer collaboration.

Expected or Actual Demographics of Participating Practices

OF PRACTICES: 7

NUMBER OF OVERALL PARTICIPATING PHYSICIANS: 25

RANGE OF NUMBER OF PHYSICIANS PER PRACTICE: 1-7

TYPES OF PRACTICES:

Internal Medicine
Family Medicine

HEALTH PLAN LINES OF BUSINESS INCLUDED:

Commercial
Medicare Advantage
Medicaid Managed Care

OVERALL NUMBER OF COVERED LIVES: 14,000

Practice Technology Characteristics at Start of Pilot:

ESTIMATED % OF PRACTICES WITH PRACTICE
MANAGEMENT SYSTEMS: >95%

ESTIMATED % OF PRACTICES WITH
ELECTRONIC MEDICAL RECORD: 51-75%

ESTIMATED % OF PRACTICES WITH
REGISTRY SOFTWARE: 51-75%

OTHER: 40% have a Web presence.

Medical Home Recognition Program:

NCQA PPC-PCMH

Practice Transformation Support (Including Technology)

Yes

FOCAL AREAS OF TRANSFORMATION:

Care Coordination

Increased Access

Information Technology (e.g., registries, patient portals)

New Pay for Performance Models

Team Approach to Care

OTHER: Care Management, Practice Culture/Teaming

ADDITIONAL DESCRIPTION:

Payment Model

Prospective Care Management PMPM Fee and
retrospective Performance Bonus PMPM.

Project Evaluation

Practices compared to market on basic cost
and quality metrics. Satisfaction surveys
for providers, staff, and patients.

▲▲ COLORADO

The Colorado Multi-Payer, Multi-State Patient-Centered Medical Home Pilot

Project Title: The Colorado Multi-Payer, Multi-State Patient-Centered Medical Home Pilot

Project Location: Colorado

REGION WITHIN STATE: Front Range

Project Status: Active

CCGC started implementing our technical assistance program with the selected practices in December 2008 to aid them in the submission of the NCQA PPC-PCMH survey. The start of the enhanced reimbursement coincides with the start date of the pilot, May 1, 2009.

TARGET START DATE: 05/01/2009

PILOT/DEMO LENGTH: 2-3 years

Convening Entity/Project Contacts

CONVENING ORGANIZATION NAME:

Colorado Clinical Guidelines Collaborative

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Brief Overview

Colorado is the site of a multi-payer, multi-state PCMH pilot that includes multiple participants at both the local and national levels. The PCMH model will be tested in 16 family medicine and internal medicine practices selected from across the Colorado Front Range as well as practices in Cincinnati, our partner region. Following an initial preparation period, payment for the two-year PCMH pilot will begin May 2009, once practices have met specific requirements to achieve at least a Level 1 NCQA Medical Home designation. Practices will receive modified payments for up to 30,000 patients covered by the participating health plans. The Colorado Clinical Guidelines Collaborative (CCGC) will serve as the convening organization and provide technical assistance for the PCMH pilot practices in Colorado, including in-office coaching, learning communities and innovative technology. The pilot will be evaluated by Meredith Rosenthal, PhD from Harvard School of Public Health to determine the effect on quality, cost trends, and satisfaction for patients and their health care team. Funding for the pilot is generously provided by The Colorado Trust and the Commonwealth Fund.

Participating Organizations

Aetna, Anthem-Wellpoint, CIGNA, Colorado Medicaid, CoverColorado, Humana, UnitedHealthcare, Colorado Business Group on Health, Centura Health, IBM, McKesson Corporation, PCPCC, State of Colorado, American Academy of Family Physicians, American College of Physicians, Colorado Academy of Family Physicians, Colorado Medical Society, Colorado Department of Health & Public Environment, University of Denver Health Science Center, Colorado Hospital Association, Centura Health, Exempla Healthcare, HealthONE Hospitals, Memorial Health System, iPN, PHP, MedSouth, NCIPA.

How have you involved the consumer in the development and implementation of your demonstration?

Formal patient advisory panel(s)

Consumer organization input incorporated in the project design process

COMMENTS: The evaluator will be conducting pre- and post-patient satisfaction surveys using the CG-CAHPS survey. The pilot practices, as part of quality improvement, will perform satisfaction surveys and will be working towards including consumers on quality improvement teams. Consumers will participate as members of a task force, advisory board members, co-trainers for staff training, mentors for other patients, reviewers of audiovisual and written materials, advocates, participants in focus groups and participants at conferences and working meetings.

Expected or Actual Demographics of Participating Practices

OF PRACTICES: 16 practices, 17 practice sites

NUMBER OF OVERALL PARTICIPATING PHYSICIANS: 51

RANGE OF NUMBER OF PHYSICIANS PER PRACTICE: 1-9

TYPES OF PRACTICES:

Internal Medicine
Family Medicine

HEALTH PLAN LINES OF BUSINESS INCLUDED:

Commercial
Medicare Advantage
Medicaid Managed Care
OTHER: Safety Net Insurer

OVERALL NUMBER OF COVERED LIVES: Approximately 25,000 under enhanced reimbursement; approximately 100,000 patient panel

Practice Technology Characteristics at Start of Pilot:

ESTIMATED % OF PRACTICES WITH PRACTICE MANAGEMENT SYSTEMS: >95%

ESTIMATED % OF PRACTICES WITH ELECTRONIC MEDICAL RECORD: >95%

ESTIMATED % OF PRACTICES WITH REGISTRY SOFTWARE: >95%

OTHER: Patient portal, e-prescribing, HIPAA compliant e-mail communication, home monitoring devices

Medical Home Recognition Program:

NCQA PPC-PCMH

Practice Transformation Support (Including Technology)

Yes

FOCAL AREAS OF TRANSFORMATION:

Care Coordination

Increased Access

Information Technology (e.g., registries, patient portals)

New Pay for Performance Models

Team Approach to Care

OTHER: Self-management support, decision support, health care organization

ADDITIONAL DESCRIPTION: CCGC practice support includes bi-monthly, in-person meetings with a multi-disciplinary team from the practice and the CCGC Quality Improvement Coach (QIC). It also includes bi-monthly webinars focused on topics centered around PCMH practice transformation and bi-annual learning collaboratives. The pilot practices are required to submit a monthly narrative report on their quality improvement initiatives along with a report of pilot measures.

SERVICES OR NEW TECHNOLOGY PARTICIPATING PRACTICES HAVE ADDED AS A RESULT OF THEIR PARTICIPATION:

The Colorado pilot practices with the assistance of their CCGC QIC are maximizing their technology and/or adding new technology to support the PCMH model. Pilot practices are required to have registry functionality and reporting for population management. Fifteen of our 16 practices had an EMR prior to the pilot. Practices are required to have a care coordinator; many of the practices have either hired or restructured their work force to support this integral role. The Colorado pilot practices have and use e-prescribing functionality.

Payment Model

- Fee for Service
- Per Member Per Month (PMPM) care management/coordination fee
- Pay for Performance (P4P)

Project Evaluation

Pre/post with a contemporaneous comparison group (observational; not RCT). It will include cost, quality, patient and staff satisfaction.

EVALUATOR NAME: Meredith Rosenthal, PhD
EVALUATOR ORGANIZATION: Harvard School of Public Health

TYPES OF DATA TO BE COLLECTED:

- Clinical Quality
- Cost/Efficiency
- Patient Experience/Satisfaction
- Provider Experience/Satisfaction

ARE THE PRACTICES INVOLVED IN THE DEMONSTRATION PARTICIPATING IN ANY DATA SHARING ARRANGEMENTS?

Yes

IF SO, WITH WHOM ARE THE PRACTICES EXCHANGING DATA (EITHER THROUGH FORMAL OR INFORMAL AGREEMENTS)?

- Demonstration project convening organization
- Practice transformation consultant(s)

WHICH OF THE DATA TYPES ARE BEING SHARED?

The pilot practices are submitting their pilot measures to CCGC monthly.

Relevant Links

www.coloradoguidelines.org/pcmh



COLORADO

Colorado Family Medicine Residency PCMH Project

Project Title: Colorado Family Medicine Residency PCMH Project
PROJECT LOCATION: Colorado

Project Status: Active
TARGET START DATE: 12/01/2008
PILOT/DEMO LENGTH: 3+ years

Convening Entity/Project Contacts

CONVENING ORGANIZATION NAME: Colorado Clinical Guidelines Collaborative, University of Colorado Denver Department of Family Medicine, Colorado Association of Family Medicine Residencies

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Brief Overview

The project is a collaborative effort between the University of Colorado Denver Department of Family Medicine, the Colorado Association of Family Medicine Residencies, and the Colorado Clinical Guidelines Collaborative, funded by the Colorado Health Foundation. The project's objective is to transform the nine Colorado Family Medicine residency

programs and ten residency practices into PCMHs through practice improvement and curriculum redesign. The project includes the use of quality improvement coaches, facilitating the formation of improvement teams within practices, using quality performance measures and other practice data to guide the design of a series of focused, rapid change cycles to accomplish practice change. Onsite coaching is supplemented with a series of Improvement Collaboratives, information technology and PCMH consultative resources. The residency curriculum redesign portion of the project consists of similar elements, but with less intensive coaching. Residency programs will implement changes in curricula to incorporate teaching of the chronic care model, quality improvement and other concepts relevant to the PCMH. The majority of PCMH teaching will be incorporated resident involvement in quality improvement and change process and in the residents' experiences caring for patients in the practice.

Participating Organizations

University of Colorado Denver Department of Family Medicine; Colorado Clinical Guidelines Collaborative; Colorado Association of Family Medicine Residencies; The Colorado Health Foundation; Colorado Institute of Family Medicine; University of Colorado Hospital Family Medicine Residency, Denver; Fort Collins Family Medicine Residency, Fort Collins; Southern Colorado Family Medicine Residency, Pueblo; North Colorado Family Medicine Residency, Greeley; Denver Health Family Medicine Track, Denver; St. Francis Hospital Family Medicine Residency, Grand Junction; St. Joseph Hospital Family Medicine Residency, Denver; St. Anthony Hospital Family Medicine Residency, Denver; Rose Hospital Family Medicine Residency, Denver; Swedish Hospital Family Medicine Residency, Denver.

How have you involved the consumer in the development and implementation of your demonstration?

Will involve patient advisors at each residency practice site. Plan to involve patient advisors for overall project and in collaborative meetings.

Expected or Actual Demographics of Participating Practices

OF PRACTICES: 10

NUMBER OF OVERALL PARTICIPATING PHYSICIANS:

Approximately 320 including residents

RANGE OF NUMBER OF PHYSICIANS

PER PRACTICE: 20–40

TYPES OF PRACTICES:

Family Medicine

HEALTH PLAN LINES OF BUSINESS INCLUDED:

All patients involved, but no health plan support for project (no change in the payment system). However, there will be some direct and indirect support for practice participation in the project through grant funding.

OVERALL NUMBER OF COVERED LIVES: Unknown

Practice Technology Characteristics at Start of Pilot:

ESTIMATED % OF PRACTICES WITH PRACTICE MANAGEMENT SYSTEMS: >95%

ESTIMATED % OF PRACTICES WITH ELECTRONIC MEDICAL RECORD: 26-50%

ESTIMATED % OF PRACTICES WITH REGISTRY SOFTWARE: 5-25%

Medical Home Recognition Program:

NCQA PPC-PCMH

Practice Transformation Support (Including Technology)

Yes

FOCAL AREAS OF TRANSFORMATION:

Care Coordination

Increased Access

Team Approach to Care

ADDITIONAL DESCRIPTION: Practice coaching used to assist practices in implementing the various aspects of the PCMH model.

SERVICES OR NEW TECHNOLOGY PARTICIPATING PRACTICES HAVE ADDED AS A RESULT OF THEIR PARTICIPATION:

Practices are in the process of adding registries, care coordination, team based care elements.

Five practices are in the process of implementing an EMR, not directly through our project but with some project support.

Project Evaluation

We will do an intensive mixed method evaluation of the project, including PCMH elements adopted, use of PCMH elements by clinicians, adoption of PCMH curricular elements, level of NCQA PPC-PCMH certification and change in the practice culture.

EVALUATOR NAME: Doug Fernald

EVALUATOR ORGANIZATION: University of Colorado Denver Department of Family Medicine

TYPES OF DATA TO BE COLLECTED:

Clinical Quality

Patient Experience/Satisfaction

Provider Experience/Satisfaction

ARE THE PRACTICES INVOLVED IN THE DEMONSTRATION PARTICIPATING IN ANY DATA SHARING ARRANGEMENTS?

Undecided

Relevant Links

<http://www.coloradoguidelines.org/pcmh/residency.asp>

<http://www.coloradoguidelines.org/pcmh/inthenews.asp>

Results to Share

Although we are early in our project and only have some preliminary findings at this point, we will be presenting our assessment methodology at the STFM/AAFP Practice Improvement Conference in Kansas City in November 2009. We plan to present some of our initial findings in other meetings in 2010.

State-by-State Guide

▲ FLORIDA

Metcare of Florida/Humana Patient-Centered Medical Home

Project Title: Metcare of Florida/Humana Patient-Centered Medical Home
PROJECT LOCATION: Florida
REGION WITHIN STATE: Central and South Florida

Project Status: Active
TARGET START DATE: 11/01/2008
PILOT/DEMO LENGTH: 1.5-2 years

Convening Entity/Project Contacts
CONVENING ORGANIZATION NAME: Humana

CONTACT NAME: Chris Corbin
CONTACT TITLE: Program Manager, Humana
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PHONE: 502/580-3820

ADDITIONAL CONTACT NAME: Jose Guethon, MD, MBA
CONTACT TITLE: President, Metcare of Florida
E-MAIL: jguethon@metcare.com
PHONE: 561/805-8500

Brief Overview

Continue to evaluate the PCMH model of care and the impact on outcomes, quality, and cost for Medicare Advantage members. We will be evaluating the performance and success of the project on key clinical, financial, satisfaction and patient-centeredness measures. The evaluation will focus on comparing quarterly data with baseline data for both the test group and control group.

Participating Organizations

Humana, Inc.; Metcare of Florida, Inc.

Expected or Actual Demographics of Participating Practices

OF PRACTICES: 9

NUMBER OF OVERALL PARTICIPATING PHYSICIANS: 17

RANGE OF NUMBER OF PHYSICIANS PER PRACTICE: 1–3

TYPES OF PRACTICES:

Internal Medicine
Family Medicine

HEALTH PLAN LINES OF BUSINESS INCLUDED:

Medicare Advantage

OVERALL NUMBER OF COVERED LIVES: 8,527

Practice Technology Characteristics at Start of Pilot:

ESTIMATED % OF PRACTICES WITH PRACTICE MANAGEMENT SYSTEMS: >95%

ESTIMATED % OF PRACTICES WITH ELECTRONIC MEDICAL RECORD: <5%

ESTIMATED % OF PRACTICES WITH REGISTRY SOFTWARE: <5%

Medical Home Recognition Program:

NCCA PPC-PCMH

Practice Transformation Support (Including Technology)

Yes

FOCAL AREAS OF TRANSFORMATION:

Care Coordination
Increased Access
Information Technology (e.g., registries, patient portals)
Team Approach to Care

ADDITIONAL DESCRIPTION: Practice transformation will be internally led within practices.

SERVICES OR NEW TECHNOLOGY PARTICIPATING PRACTICES HAVE ADDED AS A RESULT OF THEIR PARTICIPATION:

Development of patient registry and e-prescribing systems.

Project Evaluation

Yes

DESCRIPTION: Ongoing and regular analysis of practice performance to practice baseline data and comparison to patient control group performance to control group baseline

EVALUATOR ORGANIZATION: Humana

TYPES OF DATA TO BE COLLECTED:

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

ARE THE PRACTICES INVOLVED IN THE DEMONSTRATION PARTICIPATING IN ANY DATA SHARING ARRANGEMENTS?

Yes

IF SO, WITH WHOM ARE THE PRACTICES EXCHANGING DATA (EITHER THROUGH FORMAL OR INFORMAL AGREEMENTS)?

Health insurance providers involved in the demonstration

WHICH OF THE DATA TYPES ARE BEING SHARED?

Clinical, quality, cost, and satisfaction data

Relevant Links

www.metcare.com

Results to Share

Improvement in key diabetes indicators, Metcare's utilization and financial indicators better than control group.

State-by-State Guide

GEORGIA

WellStar Health System/Humana Patient-Centered Medical Home

Project Title: WellStar Health System/
Humana Patient-Centered Medical Home
PROJECT LOCATION: Georgia
REGION WITHIN STATE: Atlanta

Project Status: Active
TARGET START DATE: 05/01/2008
PILOT/DEMO LENGTH: 1.5-2 years

Convening Entity/Project Contacts
CONVENING ORGANIZATION NAME: Humana

CONTACT NAME: Chris Corbin
CONTACT TITLE: Program Manager
E-MAIL: ccorbin@humana.com
PHONE: 502/580-3820

ADDITIONAL CONTACT NAME: Jackie Hayes
CONTACT TITLE: Executive Director—Clinical Services
E-MAIL: Jackie.Hayes@wellstar.org

Brief Overview

Continue to evaluate the PCMH model of care and the impact on outcomes, quality, and cost for members in commercially insured products. We will be evaluating the performance and success of the project on key clinical, financial, satisfaction, and patient centeredness measures. The evaluation will involve a comparison of quarterly data with baseline data for both the test group and a control group.

Participating Organizations

Humana, Inc.; WellStar Health System.

Expected or Actual Demographics of Participating Practices

OF PRACTICES: 2

NUMBER OF OVERALL PARTICIPATING PHYSICIANS: 12

RANGE OF NUMBER OF PHYSICIANS PER PRACTICE: 5-7

TYPES OF PRACTICES:

Internal Medicine
Family Medicine

HEALTH PLAN LINES OF BUSINESS INCLUDED:
Commercial

OVERALL NUMBER OF COVERED LIVES: 850

Practice Technology Characteristics at Start of Pilot:

ESTIMATED % OF PRACTICES WITH PRACTICE MANAGEMENT SYSTEMS: >95%

ESTIMATED % OF PRACTICES WITH ELECTRONIC MEDICAL RECORD: <5%

ESTIMATED % OF PRACTICES WITH REGISTRY SOFTWARE: Unknown

Medical Home Recognition Program:

NCCA PPC-PCMH

Practice Transformation Support (Including Technology)

Yes

FOCAL AREAS OF TRANSFORMATION:

Care Coordination
Increased Access
Team Approach to Care

ADDITIONAL DESCRIPTION: The transformational activity is internally led by practices.

SERVICES OR NEW TECHNOLOGY PARTICIPATING PRACTICES HAVE ADDED AS A RESULT OF THEIR PARTICIPATION:

EMR and e-Prescribing system as well as a Patient Navigator service

Payment Model

Additional care coordination payment

Project Evaluation

Ongoing and regular analysis of practice performance to practice baseline data and comparison to patient control group performance to control group baseline. The control group consists of a matched patient cohort in a non-medical home primary care setting.

EVALUATOR ORGANIZATION: Humana

TYPES OF DATA TO BE COLLECTED:

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

OTHER: Patient Centeredness

ARE THE PRACTICES INVOLVED IN THE DEMONSTRATION PARTICIPATING IN ANY DATA SHARING ARRANGEMENTS?

Yes

IF SO, WITH WHOM ARE THE PRACTICES EXCHANGING DATA (EITHER THROUGH FORMAL OR INFORMAL AGREEMENTS)?

Health insurance providers involved in the demonstration

WHICH OF THE DATA TYPES ARE BEING SHARED?

Clinical, quality, cost and satisfaction data

Relevant Links

www.wellstar.org

Results to Share

Improvement in key diabetes indicators, increase in primary care services while medical expenses overall declined.

▲▲ LOUISIANA

Greater New Orleans Primary Care Access and Stabilization Grant

Project Title: Greater New Orleans Primary Care Access and Stabilization Grant (PCASG)

PROJECT LOCATION: Louisiana

REGION WITHIN STATE: Region I (Orleans, Jefferson, St. Bernard and Plaquemines parishes)

Project Status: Active

TARGET START DATE: 09/21/2007

PILOT/DEMO LENGTH: 3+ years

Convening Entity/Project Contacts

CONVENING ORGANIZATION NAME: Louisiana Public Health Institute as the local partner of the Louisiana Department of Health and Hospitals

CONTACT NAME: Clayton Williams

CONTACT TITLE: Director of Health Systems Development

E-MAIL: cwilliams@lphi.org

PHONE: 504/247-8379

ADDITIONAL CONTACT NAME: Maria Ludwick

CONTACT TITLE: Assistant Director, Primary Care Access and Stabilization Grant

E-MAIL: mludwick@lphi.org

PHONE: 504/301-9846

Brief Overview

The PCASG is a \$100 million federal grant program designed to meet the increasing demand for health care services in Greater New Orleans area post-hurricane Katrina. This is seen as an opportunity to realize a new vision for health care delivery in the area. Twenty-five public and private nonprofit organizations providing primary and mental health care were eligible for funding through the grant to stabilize, improve, and expand their

services. Outcomes at the patient, practice, and system levels are sought and will be measured in the evaluation funded by the Commonwealth Fund. Grant funds are distributed every six months according to number of patients served in the previous six-month period. Funds available each period are divided according to patient panels which are weighted according to age, payor class, and service provided. \$3.8 million were reserved for incentive payments to organizations achieving NCQA PPC-PCMH in three rounds over a one-year period. A three-year prospective study of all 25 PCASG grantee organizations and their 67 delivery sites will be conducted to evaluate progress towards the key goals of the PCASG.

Participating Organizations

US Department of Health and Human Services/Centers for Medicare & Medicaid Services; Louisiana Department of Health and Hospitals; Louisiana Public Health Institute; Tulane University; Catholic Charities Archdiocese of New Orleans; Children's Hospital Medical Practice Corp; Common Ground Health Clinic; Covenant House New Orleans; Daughters of Charity Services of New Orleans; EXCELth, Inc.; Jefferson Community Health Care Centers, Inc.; Jefferson Parish Human Services Authority; Leading Edge Services Int'l, Inc.; Lower 9th Ward Health Clinic; LSU Healthcare Network; LSU Health Sciences Center; Medical Center of Louisiana at New Orleans; Metropolitan Human Services District; New Orleans Adolescent Hospital; NO/AIDS Task Force; New Orleans Health Department; New Orleans Musicians' Assistance Foundation; Odyssey House Louisiana; Plaquemines Medical Center; St. Bernard Health Center, Inc.; St. Charles Community Health Center; St. Thomas Community Health Center; Sisters of Mercy Ministries D/B/A Mercy Family Center.

How have you involved the consumer in the development and implementation of your demonstration?

Consumer organization input incorporated in the project design process

Consumer organization input incorporated in evaluation process

COMMENTS: Consumers will be involved to assess the degree to which they are being served by a medical home, the ease of access to the clinics/providers, the ratings of patient-provider interactions and communications, the clinics’ ability to address the patient’s unique needs and the consumer perceptions about quality. Information will be collected through consumer interviews and surveys within the offices.

Expected or Actual Demographics of Participating Practices

OF PRACTICES: 91

NUMBER OF OVERALL PARTICIPATING PHYSICIANS: 324

RANGE OF NUMBER OF PHYSICIANS PER PRACTICE: 1-39

TYPES OF PRACTICES:

Internal Medicine

Family Medicine

Pediatrics

OTHER: Psychiatry and other specialists

HEALTH PLAN LINES OF BUSINESS INCLUDED:

Federal grant program

OVERALL NUMBER OF COVERED LIVES: 160,000/year

Practice Technology Characteristics at Start of Pilot:

ESTIMATED % OF PRACTICES WITH PRACTICE MANAGEMENT SYSTEMS: 76-95%

ESTIMATED % OF PRACTICES WITH ELECTRONIC MEDICAL RECORD: 26-50%

ESTIMATED % OF PRACTICES WITH REGISTRY SOFTWARE: 26-50%

Medical Home Recognition Program:

NCQA PPC-PCMH

Practice Transformation Support (Including Technology)

Yes

FOCAL AREAS OF TRANSFORMATION:

Care Coordination

Increased Access

Information Technology (e.g., registries, patient portals)

New pay for performance models

OTHER: Primary Care—Behavioral Health Integration

ADDITIONAL DESCRIPTION: Technical assistance provided/brokered by the Louisiana Public Health Institute includes network development, clinical quality improvement, practice management, business process analysis, primary-behavioral health integration, and information technology support.

SERVICES OR NEW TECHNOLOGY

PARTICIPATING PRACTICES HAVE ADDED AS A RESULT OF THEIR PARTICIPATION:

Many practices have implemented or optimized EHR and population management systems and added services to gain NCQA recognition since the start of the pilot.

Payment Model

Grant funds are distributed every six months according to number of patients served by each organization in the previous six-month period. The pool of funds available each period is divided according to the patient panels of each organization which are weighted according to age, payor class, and service provided (primary care vs. behavioral health). \$3.8 were reserved for graduated incentive payments to organizations achieving various levels of NCQA PPC-PCMH. There were three rounds in which organizations could qualify for a portion of \$1.26 million incentive pools.

Project Evaluation

The evaluation is funded by the Commonwealth Fund and measures outcomes at the patient, practice, and system levels.

EVALUATOR NAME: Diane Rittenhouse; Melinda Abrams

EVALUATOR ORGANIZATION: University of CA at San Francisco; Commonwealth Fund

TYPES OF DATA TO BE COLLECTED:

Clinical Quality

Cost/Efficiency

Patient Experience/Satisfaction

Provider Experience/Satisfaction

System-Level Utilization and Cost Data

ARE THE PRACTICES INVOLVED IN THE DEMONSTRATION PARTICIPATING IN ANY DATA SHARING ARRANGEMENTS?

Yes

IF SO, WITH WHOM ARE THE PRACTICES EXCHANGING DATA (EITHER THROUGH FORMAL OR INFORMAL AGREEMENTS)?

Other demonstration practices

Demonstration project convening organization

Practice transformation consultant(s)

WHICH OF THE DATA TYPES ARE BEING SHARED?

Clinical, quality/performance, cost/efficiency

Relevant Links

www.lphi.org

www.pcasg.org

www.gnocommunity.org

Results to Share

- Thirteen of the 25 organizations achieved recognition by NCQA as PCMHs at 36 clinic locations (ranging from levels 1-3), and more clinics are expected to achieve the recognition in 2009.
- All organizations have implemented 24/7 access to clinician by phone and same day appointments for urgent care.
- The total system volume (number of individuals served) has increased by 15% every six-month period starting March 2007 for outpatient primary and behavioral health care.
- The 25 participating organizations have expanded the number of service delivery sites from 67 pre-grant to 91 today.

▲▲ LOUISIANA

Louisiana Health Care Quality Forum Medical Home Initiative

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: Active

TARGET START DATE: 09/01/2007

PILOT/DEMO LENGTH: 3+ years

Convening Entity/Project Contacts

CONVENING ORGANIZATION NAME:

Louisiana Health Care Quality Forum

CONTACT NAME: Karen DeSalvo, MD

CONTACT TITLE: Vice Dean, Community Affairs & Health Policy, Tulane University

E-MAIL: karen.desalvo@gmail.com

PHONE: 504/957-7094

ADDITIONAL CONTACT NAME: Maggie Shipman

CONTACT TITLE: Senior Project Manager, LHCQF

E-MAIL: mshipman@lhcf.org

PHONE: 225/334-9299

Brief Overview

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 PCMH model of care. In January 2008, the LHCQF board adopted the Joint Principles of the PCMH and the NCQA standards. Currently the committee is focusing its efforts in three areas: (1) serving as a learning collaborative

for clinics and practices in LA working to meet the NCQA standards for a medical home; (2) addressing payment reforms that will support the PCMH model of care; and (3) serving on the Department of Health and Hospitals Technical Advisory Group and advising the Department on development of Medicaid PCMHs.

Participating Organizations

Tulane University; LA Office of Group Benefits; RoyOMartin Lumber Company; Blue Cross Blue Shield of Louisiana; LA State Medical Society; Ochsner Medical Center; LA Medicaid, Dept of Health and Hospitals; LA 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 Louisiana; Homecare Association of Louisiana; Capitol Area Human Services District; Franciscan Missionaries of Our Lady Health System; Louisiana Hospital Association; Children's Hospital Medical Practice Corporation; Baton Rouge Family Medical Center; North Caddo & LSU Medical Centers; Public Affairs Research Council of Louisiana; Veteran's Administration; Maternal and Child Health Coalition; Children's Special Health Services; Healthworks; Amedisys; Franklin Medical Center; LA Primary Care Association; The Rapides Foundation.

HOW HAVE YOU INVOLVED THE CONSUMER IN THE DEVELOPMENT AND IMPLEMENTATION OF YOUR DEMONSTRATION?

Consumer organization input incorporated in the project design process.

MULTI-STAKEHOLDER

Expected or Actual Demographics of Participating Practices

OF PRACTICES: >45

NUMBER OF OVERALL PARTICIPATING PHYSICIANS: >500

RANGE OF NUMBER OF PHYSICIANS PER PRACTICE: 1-150

TYPES OF PRACTICES:

Internal Medicine

Family Medicine

Pediatrics

HEALTH PLAN LINES OF BUSINESS INCLUDED:

Medicaid Managed Care

OVERALL NUMBER OF COVERED LIVES: 1,200,000

Practice Technology Characteristics at Start of Pilot:

ESTIMATED % OF PRACTICES WITH PRACTICE MANAGEMENT SYSTEMS: 26-50%

ESTIMATED % OF PRACTICES WITH ELECTRONIC MEDICAL RECORD: <5%

ESTIMATED % OF PRACTICES WITH REGISTRY SOFTWARE: <5%

Medical Home Recognition Program:

NCQA PPC-PCMH

Practice Transformation Support (Including Technology)

Yes

FOCAL AREAS OF TRANSFORMATION:

Care Coordination

Increased Access

Information Technology (e.g., registries, patient portals)

Team Approach to Care

SERVICES OR NEW TECHNOLOGY PARTICIPATING PRACTICES HAVE ADDED AS A RESULT OF THEIR PARTICIPATION:

Majority of participating practices have added an EMR and care coordinator staff.

Payment Model

Benefits package design with payment incentives to be developed.

Project Evaluation

TYPES OF DATA TO BE COLLECTED:

Clinical Quality

Cost/Efficiency

Patient Experience/Satisfaction

Provider Experience/Satisfaction

WHICH OF THE DATA TYPES ARE BEING SHARED?

Limited sharing of data across sites within same provider organizations.

Relevant Links

www.lhcqf.org



MAINE

Maine Patient-Centered Medical Home Pilot

Project Title: Maine Patient-Centered Medical Home Pilot

PROJECT LOCATION: Maine

Project Status: Active

Participating practices currently completing an initial 6-month “ramp up” period during which they’re submitting NCQA PPC-PCMH applications, and completing agreements w/ payers for new PCMH payments

TARGET START DATE: 11/01/2009

PILOT/DEMO LENGTH: 2-3 years

Convening Entity/Project Contacts

CONVENING ORGANIZATION NAME:

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

CONTACT NAME: Lisa Letourneau MD, MPH

CONTACT TITLE: PCMH Pilot Project Director,
& Executive Director, Quality Counts

E-MAIL: letourneau.lisa@gmail.com

PHONE: 207/415-4043

ADDITIONAL CONTACT NAME: Josh Cutler MD

CONTACT TITLE: Director, Maine Quality Forum

E-MAIL: josh.cutler@maine.gov

PHONE: 207/287-9959

ADDITIONAL CONTACT NAME: Elizabeth Mitchell

CONTACT TITLE: President, Maine
Health Management Coalition

E-MAIL: emitchell@mehmc.org

PHONE: 207/899-1971

Brief Overview

The Maine Patient-Centered Medical Home Pilot is the first step in achieving statewide implementation of the PCMH model. We are working with participating practices to support their continued transformation to a more patient-centered model of care, and are working with all major private payers in the state and Medicaid (MaineCare) to pilot an alternative payment model that recognizes 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. The Pilot is committed to undertaking a rigorous evaluation and plan to compare outcomes from intervention and controls groups using a quasi-experimental design with interrupted timer series.

Participating Organizations

Maine Quality Forum; Quality Counts; Maine Health Management Coalition; Anthem BCBS of Maine; Aetna; CIGNA; Harvard Pilgrim Health Care; MaineCare (Maine Medicaid); Maine Association Family Physicians; Maine Chapter, American College of Physicians; Maine American Academy of Pediatricians; Maine Medical Association; Maine Osteopathic Association; Maine Primary Care Association; Consumers for Affordable Healthcare; Multiple provider organizations; University of Maine Employees; Maine Nurse Practitioners Association.

How have you involved the consumer in the development and implementation of your demonstration?

Formal patient advisory panel(s)

Consumer organization input incorporated in the project design process

Consumer organization input incorporated in evaluation process

COMMENTS: Have also included consumers on our governance group for PCMH Pilot, and have explicit expectation that participating practices will include at least two patients or family members in their local redesign efforts. Furthermore, consumers are involved as members of a task force, reviewers of audiovisual and written materials, participants in focus groups, and participants at conferences and working meetings. Consumer family members are participants in quality improvement activities.

Expected or Actual Demographics of Participating Practices

OF PRACTICES: 26

NUMBER OF OVERALL PARTICIPATING PHYSICIANS: 221

RANGE OF NUMBER OF PHYSICIANS PER PRACTICE: 1-34

TYPES OF PRACTICES:

Internal Medicine

Family Medicine

Pediatrics

OTHER: 2 practices are residency practices (largest practice excluding residencies has 17 providers)

HEALTH PLAN LINES OF BUSINESS INCLUDED:

Commercial

OTHER: Medicaid—through Primary Care Care Management Program

OVERALL NUMBER OF COVERED LIVES: 75,000

Practice Technology Characteristics at Start of Pilot:

ESTIMATED % OF PRACTICES WITH PRACTICE MANAGEMENT SYSTEMS: 76-95%

ESTIMATED % OF PRACTICES WITH ELECTRONIC MEDICAL RECORD: 76-95%

ESTIMATED % OF PRACTICES WITH REGISTRY SOFTWARE: 76-95%

OTHER: Two practices using patient portals into their EMRs

Medical Home Recognition Program:

NCQA PPC-PCMH

COMMENTS: Practices must achieve at least Level 1 by start of Pilot.

Practice Transformation Support (Including Technology)

Yes

FOCAL AREAS OF TRANSFORMATION:

Care Coordination

Increased Access

Information Technology (e.g., registries, patient portals)

Team Approach to Care

OTHER:

Leadership; population risk stratification and management; practice-integrated care management; behavioral-physical health integration; inclusion of patients and families;

connection to community; commitment to reducing unnecessary health care spending; reducing waste and improving cost effective use of health care services. The pilot is incorporating a PCMH learning collaborative as well as external quality improvement coaches for practices.

ADDITIONAL DESCRIPTION:

Institute for Healthcare Improvement (IHI)-style PCMH learning collaborative
Practice QI coaching with external QI coach

Payment Model

Prospective care management fee (pmpm payment)

Project Evaluation

We plan to undertake a rigorous evaluation of the Maine PCMH Pilot to answer the primary research question: Does a PCMH deliver care that achieves better outcomes when compared to usual care? — i.e., does a PCMH:

- Achieve better clinical outcomes
- Better meet the needs of patients and families, including access to care
- Deliver care that is more cost efficient
- Result in greater satisfaction of patients, primary care physicians and practice teams

Information will be collected from patients, providers, clinic staff, clinical data, and billing data.

EVALUATOR NAME: Andrew Coburn

EVALUATOR ORGANIZATION: University of Southern Maine, Muskie School

TYPES OF DATA TO BE COLLECTED:

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

ARE THE PRACTICES INVOLVED IN THE DEMONSTRATION PARTICIPATING IN ANY DATA SHARING ARRANGEMENTS?

Yes

IF SO, WITH WHOM ARE THE PRACTICES EXCHANGING DATA (EITHER THROUGH FORMAL OR INFORMAL AGREEMENTS)?

Demonstration project convening organization
Practice transformation consultant(s)

WHICH OF THE DATA TYPES ARE BEING SHARED?

Clinical quality measures, patient experience of care, cost/resource use (via claims)

Relevant Links

General summary info: <http://www.mainequalitycounts.org/patient-centered-medical-home/main/>
Press release: <http://www.mainequalitycounts.org/about-qc/maine-patient-centered-medical-home-pilot-launched.html>

▲▲ MARYLAND

CareFirst BlueCross BlueShield Patient-Centered Medical Home Demonstration Program

Project Title: CareFirst BlueCross BlueShield Patient-Centered Medical Home Demonstration Program

PROJECT LOCATION: Maryland, District of Columbia and northern Virginia

Project Status: Active

TARGET START DATE: 01/01/2009

PILOT/DEMO LENGTH: 2 years

Convening Entity/Project Contacts

CONVENING ORGANIZATION NAME:

CareFirst BlueCross BlueShield

CONTACT NAME: Ann Doyle

CONTACT TITLE: Director, Clinical Innovations

E-MAIL: ann.doyle@carefirst.com

PHONE: 410/528-7992

Brief Overview

CareFirst partnered with 11 primary care practices in the MidAtlantic Region to pilot the effectiveness of the PCMH. Demonstration includes the provision of transformation consultants and use of data intermediary for the collection of clinical data from the practices. Incentives include: care coordination fee, technology grants, accreditation reimbursement if successful, outcomes rewards.

Participating Organizations

CareFirst BlueCross BlueShield.

Expected or Actual Demographics of Participating Practices

OF PRACTICES: 11

NUMBER OF OVERALL PARTICIPATING PHYSICIANS:

84 PCPs 16 MidLevel providers (NP, PA)

RANGE OF NUMBER OF PHYSICIANS PER PRACTICE: 5-13

TYPES OF PRACTICES:

Internal Medicine

Family Medicine

Pediatrics

OTHER: Practices have mixed specialties- there are no pediatric-only practices

HEALTH PLAN LINES OF BUSINESS INCLUDED:

Commercial

OTHER: All Lines of Business, Risk and Nonrisk

OVERALL NUMBER OF COVERED LIVES: >40,000 CareFirst patients (however, we represent a fraction of patients seen at those offices—number of lives touched is much greater)

Practice Technology Characteristics at Start of Pilot:

ESTIMATED % OF PRACTICES WITH PRACTICE MANAGEMENT SYSTEMS: >95%

ESTIMATED % OF PRACTICES WITH

ELECTRONIC MEDICAL RECORD: 76-95%

ESTIMATED % OF PRACTICES WITH

REGISTRY SOFTWARE: >95%

OTHER: Registry functions are included in the capabilities of data intermediary we are providing. We also provided a technology grant to move practices to a higher level of patient centeredness. Some practices have lab interfaces and patient portals, etc.

Medical Home Recognition Program:

NCQA PPC-PCMH

COMMENTS: At least level 2 by end of Year 1

**Practice Transformation Support
(Including Technology)**

Yes

FOCAL AREAS OF TRANSFORMATION:

Care Coordination

Increased Access

Information Technology (e.g., registries, patient portals)

New Pay for Performance Models

Team Approach to Care

OTHER: NCQA PPC-PCMH support

ADDITIONAL DESCRIPTION: TransforMED on site with Collaboratives four times per year

SERVICES OR NEW TECHNOLOGY

PARTICIPATING PRACTICES HAVE ADDED AS

A RESULT OF THEIR PARTICIPATION:

EMR, registry, portals, lab/radiology interfaces, electronic registration systems, Web sites

Payment Model

Care coordination fee, technology grants and outcomes rewards

Project Evaluation

Clinical, CAHPS Clinician & Group Survey, cost efficiency

TYPES OF DATA TO BE COLLECTED:

Clinical Quality

Cost/Efficiency

Patient Experience/Satisfaction

ARE THE PRACTICES INVOLVED IN THE DEMONSTRATION PARTICIPATING IN ANY DATA SHARING ARRANGEMENTS?

Yes

COMMENTS: TransforMED's delta exchange

IF SO, WITH WHOM ARE THE PRACTICES EXCHANGING DATA (EITHER THROUGH FORMAL OR INFORMAL AGREEMENTS)?

Other demonstration practices

Practice transformation consultant(s)

WHICH OF THE DATA TYPES ARE BEING SHARED?

Clinical, Quality/performance, CAHPS Clinician & Group Survey, Personal experiences

▲▲ MARYLAND

National Naval Medical Center Medical Home Program

Project Title: National Naval Medical Center Medical Home Program

PROJECT LOCATION: Maryland

REGION WITHIN STATE: National Naval Medical Center (NNMC), Bethesda

Project Status: Active

START DATE: 4/1/2008

PILOT/DEMO LENGTH: Ongoing

Convening Entity/Project Contacts

CONVENING ORGANIZATION NAME:

NNMC, Internal Medicine

CONTACT NAME: Kevin Dorrance, MD

E-MAIL: Kevin.Dorrance@med.navy.mil

PHONE: 301/295-4805

ADDITIONAL CONTACT NAME: Sean Lynch

E-MAIL: Sean.Lynch@med.navy.mil

PHONE: 301/319-4399

ADDITIONAL CONTACT NAME: Sunny Ramchandani, MD

E-MAIL: Sunny.Ramchandani@med.navy.mil

Brief Overview

The NNMC Patient Centered Medical Home Pilot Program is the only existing PCMH pilot program in Military Health System (MHS). An enrolled pilot group of 11,500 patients will be compared to the remaining 11,000 beneficiaries along quality, cost, and satisfaction parameters. A health care team, or "Clinical Micropractice" (CM), forms the fundamental unit of care, consisting of three providers, one registered nurse, three licensed practical nurses/corpsmen, and two administrative assistants. The CM is

responsible for managing acute, chronic and preventive care as well as coordinating studies and subspecialty care for all assigned patients. Clinical decision support tools, evidence-based practice guidelines and real-time performance monitoring are incorporated into the daily practice. Teams use an Oracle based dashboard to proactively schedule appointments and manage diabetes, CHF, asthma, COPD, as well as arrange preventive services to include cervical cancer screening, mammography, and colon cancer screening. The CM also encourages patients to engage in the management of their own health by providing them with resources, education and skills via improvements in information technology and the implementation of a self management program. Patients can schedule same-day acute appointments with their primary provider and can schedule routine appointments within 2-3 days. Subspecialty appointments are booked upon discharge from the clinical visit by the PCMH team. The model includes integration of behavioral health consultants and nutrition therapists at the point of care.

Provider Organizations

Internal Medicine, National Naval Medical Center, U.S. Navy.

Expected or Actual Demographics of Participating Practices

NUMBER OF PRACTICES: 1

NUMBER OF OVERALL PARTICIPATING PHYSICIANS: 25 (adding 10 Pediatricians 2009)

TYPES OF PRACTICES

Internal Medicine

HEALTH PLAN LINES OF BUSINESS INCLUDED

U.S. Navy Military Health System (MHS)

OVERALL NUMBER OF COVERED LIVES

35,390

Medical Home Recognition Program:

NCQA PPC-PCMH

MHS Specific Measures of Success

Practice Transformation Support (Including Technology)

Our Medical Home Management Portal was developed to monitor and manage the enrolled population, and is currently being expanded to include a wide range of disease management tools. In order to improve patient communication and reduce unnecessary clinic encounters we have implemented the use of a commercial Personal Health Record that provides both synchronous and asynchronous communication and virtual office visits.

We are currently building a new Medical Center, which has been specifically designed to meet the team-based requirements of the Medical Home model: decentralized patient check-in, with an emphasis on the healing environment and a shared office concept to create the ideal team environment to add value to patient care.

Project Evaluation

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

Relevant Links

http://www.bethesda.med.navy.mil/patient/health_care/medical_services/internal_medicine/medical_home.aspx

Results to Share

PCM continuity of care increase of 33%; 20.8% decrease in network ER visits per 100 enrollees; 39.5% decrease in total annual ER visits per 100 enrollees; 40.4% decrease in total specialty care visits per 100 enrollees.

The views expressed in this presentation are those of the authors and do not necessarily reflect the official policy or position of the Department of the Navy, Department of Defense, nor the U.S. Government.

▲▲ MICHIGAN

Blue Cross Blue Shield of Michigan–Physician Group Incentive Program

Project Title: Blue Cross Blue Shield of Michigan–Physician Group Incentive Program (PGIP)

PROJECT LOCATION: Michigan

REGION WITHIN STATE: Statewide

Project Status: Active

TARGET START DATE: 01/01/2005

PILOT/DEMO LENGTH: 3+ years

Convening Entity/Project Contacts

CONVENING ORGANIZATION NAME: Blue Cross Blue Shield of Michigan

CONTACT NAME: David Share, M.D.

CONTACT TITLE: Medical Director, Health Care Quality

E-MAIL: dshare@bcbsm.com

PHONE: 248/448-6142

ADDITIONAL CONTACT NAME: Margaret Mason

CONTACT TITLE: Health Care Manager

E-MAIL: mmason@bcbsm.com

PHONE: 248/448-5723

Brief Overview

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 percent of physician payment. Current program is for PPO. One percent of physician payment 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 organized 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 status 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. More than 80 physician organizations including more than 2,400 practices are accountable for transforming practices, establishing shared information systems and care process guided by the PCMH model.

Participating Organizations

Advantage Health Physicians; Bronson Medical Group; CIPA; DMC Primary Care Physicians, P.C.; Genesys Integrated Group Physicians; Henry Ford Medical Group; HVPA; Integrated Health Associates; Integrated Health Partners; Jackson Physician Alliance; Livingston Physician Organization, LLP; McLaren Medical Management; Medical Network One; Mercy Community Physician PHO; Michigan Medical, PC; Michigan State University Health Team; Midwest Medical Center; Oakland Physician Network Services; Oakland Southfield Physicians, PC; Olympia Medical Services PLLC; Oncology Physician Resource (OPR); Physician Healthcare Network, PC; Primary Healthcare Partners, Inc. (Covenant); Principal Health PHO; Professional Medical Corporation, PC; Promed Healthcare; Quality Partners of Michigan; RDN West Michigan; Sparrow Medical Group; St. John Healthpartners; St. John Medical Group, PC; United Physicians, PC; University of Michigan Health System; UOP, LLC; Upper Peninsula Health Plan; West Michigan Physicians Network.

How have you involved the consumer in the development and implementation of your demonstration?

(1) Indirect consumer input via physician organizations that partner with BCBSM on the PCMH program; and (2) patient satisfaction survey (2008)

Expected or Actual Demographics of Participating Practices

OF PRACTICES: 3,072

NUMBER OF OVERALL PARTICIPATING PHYSICIANS: 7,618

RANGE OF NUMBER OF PHYSICIANS PER PRACTICE:

Range is 1-90; Average is 2.5

TYPES OF PRACTICES:

Internal Medicine

Family Medicine

Pediatrics

OTHER: Geriatrics, specialists (oncologists, cardiologists, OB-GYNs, etc.), mixed PCP/specialist practices

OVERALL NUMBER OF COVERED LIVES: 1,700,000

Practice Technology Characteristics at Start of Pilot:

ESTIMATED % OF PRACTICES WITH PRACTICE MANAGEMENT SYSTEMS: Unknown

ESTIMATED % OF PRACTICES WITH ELECTRONIC

MEDICAL RECORD: Unknown

ESTIMATED % OF PRACTICES WITH REGISTRY

SOFTWARE: <5%

OTHER: While we collect data regarding which software systems and other technology are at use at the practice

units, we do not collect data about the number of practices that are using the particular technology systems, with the exception of patient registry.

Medical Home Recognition Program:

COMMENTS: 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)

Yes

FOCAL AREAS OF TRANSFORMATION:

Care Coordination

Increased Access

Information Technology (e.g., registries, patient portals)

Team Approach to Care

OTHER: Test results tracking, performance reporting, and establishing preventive care programs.

ADDITIONAL DESCRIPTION: Learning collaboratives for providers, incentives to physicians that meet goals towards "initiative tasks" before functioning as a PCMH; 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 PCMH. The transformational approach also includes lean management clinic process re-engineering.

SERVICES OR NEW TECHNOLOGY PARTICIPATING PRACTICES HAVE ADDED AS A RESULT OF THEIR PARTICIPATION: Patient registry systems, e-prescribing technology, patient Web portals and electronic health records. We have also seen practices dedicating or adding staff positions for the purposes of care coordination and care planning, including disease-specific health care travel teams and/or health care navigators.

Payment Model

PGIP-enrolled primary care physicians who are members of a designated PCMH practice receive a higher level of reimbursement for office-based E&M codes from July 1 through June 30 of the following year. For 2009, the uplift was 10 percent, but it will be reviewed annually. In addition, all practices and providers that participate in PGIP are eligible to receive payments for care coordination (T codes). Finally, all physician organizations are eligible to receive incentive pool payments based on the practice transformation and performance outcomes of their associated practices. The incentive payments are used by the POs and passed down to physicians and practice units at the discretion of the PO to facilitate practice transformation and clinical quality outcomes.

Project Evaluation

Yes

EVALUATOR NAME: Primary evaluator is BCBSM, including Darline El Reda, Ann Annis Emeott, Dr. Richard E. Ward, and Dr. David Share. Secondary evaluator is Chris Wise, PhD.
EVALUATOR ORGANIZATION: Primary is Blue Cross Blue Shield of Michigan, and secondary is University of Michigan—Center for Healthcare Research and Transformation

TYPES OF DATA TO BE COLLECTED:

Clinical Quality
Cost/Efficiency
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)

ARE THE PRACTICES INVOLVED IN THE DEMONSTRATION PARTICIPATING IN ANY DATA SHARING ARRANGEMENTS?

Yes

IF SO, WITH WHOM ARE THE PRACTICES EXCHANGING DATA (EITHER THROUGH FORMAL OR INFORMAL AGREEMENTS)?

Demonstration project convening organization
Practice transformation consultant(s)

WHICH OF THE DATA TYPES ARE BEING SHARED?

Progress toward implementation of PCMH capabilities, quality and use data, and qualitative data regarding planning for practice transformation activities; barriers to success, catalysts of success, and methods used to collaborate with other providers.

Relevant Links

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

Results to Share

We expect to conduct a comprehensive Program Year 1 evaluation in the Fourth Quarter of 2010, which is one year after end of Program Year #1. Some examples of accomplishments to date include:

- For 2008, improved quality of care of patients with chronic conditions (shown by reports that compare the performance of physician organizations to non-PGIP physicians on 18 national standard measures)
- 6.0 percent higher generic drug dispensing rate, 2008q3 – 2008q4
- For 2008, 11.8 percent lower overall radiology use and an 11.9 percent lower high tech radiology use, resulting in an estimated \$7.9 million savings, 2008q4 – 2009q3
- For 2008, 20 percent lower inpatient discharge rate for ambulatory care sensitive conditions (ACSC), such as asthma and high blood pressure, and 23 percent lower ACSC related inpatient costs.

State-by-State Guide

▲▲ MICHIGAN

Priority Health PCMH Grant Program

Project Title: Priority Health PCMH Grant Program

PROJECT LOCATION: Michigan

Project Status: Active

Other Phase one completes 10-31-09 with phase two going through 3/31/2011

TARGET START DATE: 11/01/2008

PILOT/DEMO LENGTH: 2-3 years

Convening Entity/Project Contacts

CONVENING ORGANIZATION NAME: Priority Health

CONTACT NAME: James F. Byrne, MD

CONTACT TITLE: Chief Medical Officer

E-MAIL: jim.byrne@priorityhealth.com

PHONE: 616/464-8362

ADDITIONAL CONTACT NAME: Mindy Olivarez, MBA

CONTACT TITLE: Senior Program Manager, PCMH

E-MAIL: mindy.olivarez@priorityhealth.com

PHONE: 616/464-8614

ADDITIONAL CONTACT NAME: Steve Williams

CONTACT TITLE: Director of Provider Strategy

E-MAIL: steve.williams@priorityhealth.com

PHONE: 616/464-8269

Brief Overview

The Priority Health pilot seeks to demonstrate the value of specific attributes of the PCMH: access, care coordination and patient engagement. However, other PCMH attributes are impacted and are recognized. The emphasis is on improving population health, improving patient experience and reducing per capita costs. Priority Health provided grants to a limited number of PHO/PO or independent

practices proposing to achieve the triple aim and allowing us to study their practice re-design around PCMH. Grantee sites receive plan-provided case management resources and reporting specific to outcomes, along with member stratification reports to assist in care delivery. Grantees have access to an external evaluator to assist in building capacity to identify and measure the process and clinical changes. Priority Health is also aligning reimbursement by providing enhanced reimbursement to all Priority Health primary care providers and significant transformation support to a subset of practices.

Participating Organizations

Priority Health; TransforMED; Michigan State University, College of Human Medicine.

How have you involved the consumer in the development and implementation of your demonstration?

Consumer organization input incorporated in evaluation process.

COMMENTS: Evaluating patient and provider experience by using both the PACIC and Primary Care Assessment Tool

Expected or Actual Demographics of Participating Practices

OF PRACTICES: 16-17

NUMBER OF OVERALL PARTICIPATING PHYSICIANS: 108

RANGE OF NUMBER OF PHYSICIANS PER PRACTICE: 1-19

TYPES OF PRACTICES:

Internal Medicine
 Family Medicine
 Pediatrics

OTHER: In one of the practices with 19 providers they are also including their OBGYN, General Surgery, and orthopedics partners

HEALTH PLAN LINES OF BUSINESS INCLUDED: Commercial

OVERALL NUMBER OF COVERED LIVES: Phase two is 36,300—phase one was 23,000

Practice Technology Characteristics at Start of Pilot:

ESTIMATED % OF PRACTICES WITH PRACTICE MANAGEMENT SYSTEMS: 76-95%

ESTIMATED % OF PRACTICES WITH ELECTRONIC MEDICAL RECORD: 26-50%

ESTIMATED % OF PRACTICES WITH REGISTRY SOFTWARE: 5-25%

OTHER: E-prescribing, registries, patient portals

Medical Home Recognition Program:

NCQA PPC-PCMH

COMMENTS: This is not a requirement but any Priority Health practice that applies is able to get reimbursement for achieving it.

Practice Transformation Support (Including Technology)

Yes

FOCAL AREAS OF TRANSFORMATION:

Care Coordination
 Increased Access
 Information Technology (e.g., registries, patient portals)
 New Pay for Performance Models
 Team Approach to Care

OTHER: Using TransforMED in multiple pilot sites and an external evaluator to work with practices and plan.

SERVICES OR NEW TECHNOLOGY PARTICIPATING PRACTICES HAVE ADDED AS A RESULT OF THEIR PARTICIPATION:

Registry, care coordinators, additional staff, patient portals, Web sites, tracking mechanisms, updated practice management systems

Payment Model

Grantees received up-front funding in form of grants and the whole contracted Priority Health network received enhanced reimbursement in the form of increased capitation, ability to bill for new FFS codes that support access and patient engagement, and NCQA PPC-PCMH reimbursement for achieving any of the levels in 2009.

Project Evaluation

For plan and pilot sites providing an overall evaluation of clinical, utilization (cost) and patient and provider experience. Also looking at changes within the practices based on their interventions.

EVALUATOR NAME: Rebecca Malouin, PhD. MPH

EVALUATOR ORGANIZATION: Michigan State University, College of Human Medicine



TYPES OF DATA TO BE COLLECTED:

Clinical Quality

Cost/Efficiency

Patient Experience/Satisfaction

Provider Experience/Satisfaction

ARE THE PRACTICES INVOLVED IN THE DEMONSTRATION PARTICIPATING IN ANY DATA SHARING ARRANGEMENTS?

Yes

IF SO, WITH WHOM ARE THE PRACTICES EXCHANGING DATA (EITHER THROUGH FORMAL OR INFORMAL AGREEMENTS)?

Other demonstration practices

Demonstration project convening organization

Practice transformation consultant(s)

WHICH OF THE DATA TYPES ARE BEING SHARED?

All grantee sites receive their own and each others' clinical/ quality improvement performance, cost/efficiency, and patient and provider experience outcomes through the use of a plan-provided PCMH dashboard.

Relevant Links

<http://www.priorityhealth.com/provider/manual/performance/medical-home>

<http://www.transformed.com>

Results to Share

Available in 2010.

▲▲ NEW HAMPSHIRE

CIGNA and Dartmouth-Hitchcock Patient-Centered Medical Home Pilot

Project Title: CIGNA and Dartmouth-Hitchcock Patient-Centered Medical Home Pilot

PROJECT LOCATION: New Hampshire

Project Status: Active

TARGET START DATE: 06/01/2008

PILOT/DEMO LENGTH: 2-3 years

Convening Entity/Project Contacts

Convening Organization Name: CIGNA HealthCare

CONTACT NAME: Harriet Wallsh, RN

CONTACT TITLE: Performance Measurement & Improvement

E-MAIL: Harriet.Wallsh@CIGNA.com

PHONE: 407/691-0103

Brief Overview

CIGNA and Dartmouth-Hitchcock (D-H) launched a PCMH pilot program June 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 and 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 encourages patient access to key programs.

Participating Organizations

CIGNA HealthCare; Dartmouth-Hitchcock Clinic.

How have you involved the consumer in the development and implementation of your demonstration?

Formal patient advisory panel(s)

COMMENTS: Consumers are involved in focus groups, review of materials, and advisory panels at D-H.

Expected or Actual Demographics of Participating Practices

OF PRACTICES: 5

NUMBER OF OVERALL PARTICIPATING PHYSICIANS: 253

RANGE OF NUMBER OF PHYSICIANS PER PRACTICE: approximately 25

TYPES OF PRACTICES:

Internal Medicine

Family Medicine

Pediatrics

HEALTH PLAN LINES OF BUSINESS INCLUDED:

Commercial

OVERALL NUMBER OF COVERED LIVES: 16,600

Practice Technology Characteristics at Start of Pilot:

ESTIMATED % OF PRACTICES WITH PRACTICE MANAGEMENT SYSTEMS: >95%

ESTIMATED % OF PRACTICES WITH ELECTRONIC MEDICAL RECORD: >95%

Estimated % of practices with registry software: >95%

OTHER: Patients may schedule appointments on line, have e-visits, health record access, and self management tools through the D-H library

Medical Home Recognition Program:

NCQA PPC-PCMH

Practice Transformation Support (Including Technology)

Yes

FOCAL AREAS OF TRANSFORMATION:

Care Coordination

Increased Access

Information Technology (e.g., registries, patient portals)

New pay for performance models

Team Approach to Care

ADDITIONAL DESCRIPTION:

1. Steering committee meetings to engage leadership and operational teams. Initially on a monthly basis, the meetings evolved to quarterly conference calls
2. Operational work group calls implemented weekly to ramp up and execute the medical home efforts for both D-H and CIGNA, meetings have evolved into monthly conference calls with additional contacts on an as-needed basis
3. D-H and CIGNA collaboratively developed a medical

management model engaging programs from both entities. The D-H medical management team reviews patients recommended by CIGNA or D-H for case management (CM) or disease management (DM) programs and providing CM or DM and outcome or closure to CIGNA. An outcome of the process development is reduction of duplicative services by both CIGNA and Dartmouth. Patients have been receptive to outbound calls from their physician at D-H resulting in patient acceptance of program participation.

4. Gaps in Care review process—D-H developed a process for active review and feedback for each month the electronic GIC report was submitted beginning in April 2008. The D-H review and communications with CIGNA provided opportunity and information for CIGNA to enhance the report data and format to be more useful by physician practices, another example of the collaborative efforts and positive working relationship between D-H and CIGNA.
5. The first version of a high-risk report was developed in collaboration with D-H, using the D-H gold star criteria, and then modified to identify those patients that may be in need of more focused care. The D-H team is providing feedback to develop a user-friendly version of CIGNA's PreVise report to identify high risk patients specific to each medical home practice as the "next generation" report to identify the high risk patient population.
6. Together, the D-H and CIGNA teams developed patient satisfaction questions using CAHPS and the D-H patient surveys to identify those questions that best measured a medical home. D-H began implementing the patient satisfaction survey questions for the PCMH population on their existing patient satisfaction questionnaire. Results are shared quarterly.

SERVICES OR NEW TECHNOLOGY PARTICIPATING PRACTICES HAVE ADDED AS A RESULT OF THEIR PARTICIPATION:

1. D-H's Regional Primary Care Center is charged with implementing the PCMH concept at D-H, resulting in NCQA recognition for several of its practices; other practices are expected to follow suit. The Center will facilitate the evolution of primary care through a comprehensive PCMH in partnerships with patients, families, the community, and the greater health care system.
2. The Regional Primary Care Center supports various committees to vet and implement operational strategies in support of the medical home concept, such as evidence based care guidelines, patient communications, access to services, optimizing workflows.
3. Embedded care coordinators were added to each practice location to support patient care and care plan development; act as patient navigators; ensure patient transitions (i.e. post-hospital discharge, MD-MD) are smooth and completed; and support patient education, family inclusion, greater knowledge of CIGNA and community resources and their use as needed. Written resources including instructions for self care/day care plans and when/who to call for support are shared with patients.
4. Patient data coordinators have been added to each practice to work with the disease management registries for each physician, to identify service or test needs based on evidence based care guidelines, and either order the service based on standard ordering guidelines or communicate the need to the patient care team.
5. Process improvement and workflow reengineering has been implemented for all D-H practice locations to support the medical home concept.
6. E-prescribing—D-H has implemented ePrescribing in the Concord & Keene locations but it is not currently in sites with the D-H CIS home-grown electronic health records. The CIS sites will change over to EPIC and then have ePrescribing capabilities with a target of transition in 2011.

Payment Model

Enhanced fee schedule plus reward for outcomes based on improvements in quality and affordability of care.

Project Evaluation

CIGNA will evaluate quality (EBM) and total medical cost measures

EVALUATOR ORGANIZATION: CIGNA HealthCare

TYPES OF DATA TO BE COLLECTED:

Clinical Quality
Cost/Efficiency
Patient Experience/Satisfaction

ARE THE PRACTICES INVOLVED IN THE DEMONSTRATION PARTICIPATING IN ANY DATA SHARING ARRANGEMENTS?

Yes

IF SO, WITH WHOM ARE THE PRACTICES EXCHANGING DATA (EITHER THROUGH FORMAL OR INFORMAL AGREEMENTS)?

Health insurance providers involved in the demonstration

WHICH OF THE DATA TYPES ARE BEING SHARED?

Clinical data share

▲▲ NEW HAMPSHIRE

NH Multi-Stakeholder Medical Home Pilot

Project Title: NH Multi-Stakeholder Medical Home Pilot

PROJECT LOCATION: New Hampshire

REGION WITHIN STATE: Statewide

Project Status: Active

Pilot sites submitted to NCQA for 05/01/2009 and began receiving payments effective 06/01/2009.

TARGET START DATE: 01/01/2009

PILOT/DEMO LENGTH: 2-3 years

Convening Entity/Project Contacts

Convening Organization Name: New Hampshire Citizens Health Initiative

CONTACT NAME: Heather Staples

CONTACT TITLE: Consultant

E-MAIL: hstaples_walden@hotmail.com

PHONE: 603/491-2701

ADDITIONAL CONTACT NAME: Ned Helms

CONTACT TITLE: Director

E-MAIL: nedhelms3@aol.com

PHONE: 603/862-5030

Brief Overview

The goal of the NH Multi-Stakeholder Medical Home Pilot is to prescribe, value and reward medical care that is tightly coordinated, patient-centered, and of superior quality and efficiency. Our research questions are as follows:

- If payers and providers make the investment in PCMHs, can it create value (as defined by cost savings or higher quality of care)?
- Will there be sufficient value created to cover costs of investment? and

- What are the metrics that are best correlated to value creation?

Our focus is on the adult populations in primary care settings that range from rural to urban populations and in independent, hospital-owned, and community health center practices.

Participating Organizations

NH Citizens Health Initiative; Anthem Blue Cross Blue Shield of NH; Cigna Health Care of NH; Harvard Pilgrim Health Care; MVP Healthcare; NH Medicaid; Center for Medical Home Improvement; NH Institute for Health Policy and Practice; Dartmouth Hitchcock Medical Center; Ammonoosuc Community Health Services; Concord Hospital Health Center; Dartmouth Hitchcock Medical Center Keene; Derry Medical Center; Elliot Family Medicine at Bedford Commons; Lamprey Health Care; Life Long Care; Mid-State Health Center; Westside Healthcare/LRGH.

Expected or Actual Demographics of Participating Practices

OF PRACTICES: 9

NUMBER OF OVERALL PARTICIPATING PHYSICIANS: 63

RANGE OF NUMBER OF PHYSICIANS PER PRACTICE: 2-17

TYPES OF PRACTICES:

Internal Medicine
Family Medicine

HEALTH PLAN LINES OF BUSINESS INCLUDED: Commercial

OVERALL NUMBER OF COVERED LIVES: 39,000
Commercial Lives and 130,000 unique patient visits
per year

Practice Technology Characteristics at Start of Pilot:

ESTIMATED % OF PRACTICES WITH PRACTICE MANAGEMENT SYSTEMS: >95%
ESTIMATED % OF PRACTICES WITH ELECTRONIC MEDICAL RECORD: >95%
ESTIMATED % OF PRACTICES WITH REGISTRY SOFTWARE: 76-95%
OTHER:
100% of sites have electronic prescribing
100% of sites import emergency room, hospital, lab, and radiology data into the medical record
60% communicate with patients using email
60% can view prescription information through a patient portal
33% have a personal health record
67% have an electronic care plan

Medical Home Recognition Program:

NCQA PPC-PCMH

Practice Transformation Support (Including Technology)

No

ADDITIONAL DESCRIPTION: Although we are not providing direct transformation support, a number of the sites have received direct support and we are providing continuing opportunities for transformation through collaboration during the pilot period.

SERVICES OR NEW TECHNOLOGY PARTICIPATING PRACTICES HAVE ADDED AS A RESULT OF THEIR PARTICIPATION:

Sites have added registry functions, care coordinators, and other staff members.


Payment Model

The sites are paid a prospective per member per month fee that increases with NCQA Recognition Level. The recommended mid-point, across all PCMH Recognition Levels is \$4 pmpm. The fee is paid directly by the participating carriers every six months for adult members in the practice. The carriers additionally have included their existing pay for performance programs for improvements in quality and cost.

Project Evaluation

Outcomes of care delivered by the PCMH pilot practices will be measured at baseline and over the two-year course of the Pilot. Outcomes will include measures that reflect the IOM definition of quality—i.e., care that is safe, effective, timely, patient-centered, equitable, and efficient. Outcomes can be grouped into the following:

- i. Clinical outcomes—consistent with CMS Group Practice Demonstration metrics—e.g., chronic illness process and outcomes measures (e.g., for diabetes, cardiovascular disease, asthma, depression), preventive care process measures (e.g., immunization rates, screening rates for cervical, breast, colon cancer)
- ii. Patient experience of care—as measured by validated tools—e.g., CG-CAHPS survey (AHRQ),
- iii. Resource use/costs—e.g., total health care costs, emergency department visits, hospitalizations/re-hospitalizations, ambulatory-sensitive hospitalizations,



high-end imaging for targeted conditions (e.g., MRI, CT for back pain), generic drug utilization rates.

EVALUATOR ORGANIZATION: NH Institute for Health Policy and Practice

TYPES OF DATA TO BE COLLECTED:

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

ARE THE PRACTICES INVOLVED IN THE DEMONSTRATION PARTICIPATING IN ANY DATA SHARING ARRANGEMENTS?

Yes

IF SO, WITH WHOM ARE THE PRACTICES EXCHANGING DATA (EITHER THROUGH FORMAL OR INFORMAL AGREEMENTS)?

Health insurance providers involved in the demonstration

WHICH OF THE DATA TYPES ARE BEING SHARED?

Clinical, quality, and performance data.

Relevant Links

NH Citizens Health Initiative Web site
www.stepsupnh.org
Center for Medical Home Improvement
www.medicalhomeimprovement.org

▲▲▲ NEW YORK

CDPHP Patient-Centered Medical Home Pilot

Project Title: CDPHP Patient-Centered Medical Home Pilot

PROJECT LOCATION: New York

REGION WITHIN STATE: Albany

Project Status: Active

TARGET START DATE: 05/22/2008

PILOT/DEMO LENGTH: 3+ years

Convening Entity/Project Contacts

CONVENING ORGANIZATION NAME: Capital District Physician's Health Plan (CDPHP)

CONTACT NAME: Lisa Sasko

CONTACT TITLE: Director

E-MAIL: Lsasko@cdphp.com

PHONE: 518/641-3217

ADDITIONAL CONTACT NAME: Dr. Bruce Nash

CONTACT TITLE: Senior Vice President, Medical Affairs and Chief Medical Officer

E-MAIL: bnash@cdphp.com

PHONE: 518/641-3211

Brief Overview

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/reimbursement model and support practice adoption of the medical home.

Participating Organizations

Capital District Physician's Health Plan; Community Care Physicians, P.C.; Capital Care Medical Group; TransformMED.

How have you involved the consumer in the development and implementation of your demonstration?

COMMENTS: Patients have been involved in practice focus groups and learning collaboratives. Family members have also been involved in learning collaboratives.

Expected or Actual Demographics of Participating Practices

OF PRACTICES: 3

NUMBER OF OVERALL PARTICIPATING PHYSICIANS: 18

RANGE OF NUMBER OF PHYSICIANS PER PRACTICE: 3-10

TYPES OF PRACTICES:

Internal Medicine

Family Medicine

HEALTH PLAN LINES OF BUSINESS INCLUDED:

Commercial

Medicare Advantage

Medicaid Managed Care

OVERALL NUMBER OF COVERED LIVES:

Approximately 13,500

Practice Technology Characteristics at Start of Pilot:

ESTIMATED % OF PRACTICES WITH PRACTICE MANAGEMENT SYSTEMS: 51-75%

ESTIMATED % OF PRACTICES WITH ELECTRONIC MEDICAL RECORD: >95%

ESTIMATED % OF PRACTICES WITH REGISTRY SOFTWARE: 51-75%

Medical Home Recognition Program:

NCQA PPC-PCMH

COMMENTS: We recognize that NCQA PPC-PCMH Level 3 is necessary but not sufficient. With that said, we currently require NCQA Level 3 certification by end of 2009 and will add additional criteria for the next phase of work (practices joining our medical home model in 2011).

Practice Transformation Support (Including Technology)

Yes

FOCAL AREAS OF TRANSFORMATION:

Care Coordination

Increased Access

Information Technology (e.g., registries, patient portals)

New Pay for Performance Models

Team approach to care

ADDITIONAL DESCRIPTION: CDPHP has partnered with TransforMED to lead our practices through the practice transformation efforts. CDPHP provided start-up funding to assist the practices in their early transition (i.e., (\$6,000 stipend per month for the initial eight months of 2008). CDPHP continued in 2009 with a \$35,000 stipend per

full-time physician to offset the costs of transformation and will do so again in 2010.

SERVICES OR NEW TECHNOLOGY PARTICIPATING PRACTICES HAVE ADDED AS A RESULT OF THEIR PARTICIPATION:

Practices incorporated the use of population management tools (CINA), patient registries, and altered existing staff structures to incorporate PCMH focused care coordination roles/responsibilities and a patient-centric team-based approach to care.

Payment Model

The CDPHP payment model is a capitation plus bonus incentive (based on quality and efficiency) model, which began January 2009 for the three practice sites.

Project Evaluation

The details of the project evaluation are currently in development.

TYPES OF DATA TO BE COLLECTED:

Clinical Quality—Practices will be measured on 18 HEDIS Quality Metrics at the practice level.

Cost/Efficiency—Practices will be measured on three efficiency domains, specifically: (1) Utilization-based hospital and ED rates (ambulatory case sensitive conditions); (2) Population-based efficiency metrics; and (3) Episode-based medical costs for eight clinical conditions.

Patient Experience/Satisfaction—CG CAHPS+ PCMH specific survey questions.

Provider Experience/Satisfaction—Survey

ARE THE PRACTICES INVOLVED IN THE DEMONSTRATION PARTICIPATING IN ANY DATA SHARING ARRANGEMENTS?

Yes

IF SO, WITH WHOM ARE THE PRACTICES EXCHANGING DATA (EITHER THROUGH FORMAL OR INFORMAL AGREEMENTS)?

Health insurance providers involved in the demonstration
Practice transformation consultant(s)

WHICH OF THE DATA TYPES ARE BEING SHARED?

Clinical quality/performance and cost/efficiency

Relevant Links

www.cdphp.com

Results to Share

We expect to have results to share in 2010.

▲▲▲ NEW YORK

EmblemHealth Medical Home High Value Network Project

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

TARGET START DATE: 01/01/2008

PILOT/DEMO LENGTH: 1.5–2 years

Convening Entity/Project Contacts

CONVENING ORGANIZATION NAME: EmblemHealth

CONTACT NAME: William Gillespie, MD

CONTACT TITLE: SVP & Chief Medical Officer

E-MAIL: wgillespie@emblemhealth.com

PHONE: 646/447-5797

ADDITIONAL CONTACT NAME: Amin Hakim, MD

CONTACT TITLE: Senior Medical Director, EmblemHealth

E-MAIL: ahakim@emblemhealth.com

PHONE: 646/447-7505

ADDITIONAL CONTACT NAME: Judith Fifield, PhD

CONTACT TITLE: Director, Ethel Donaghue Center for Translating Research into Practice and Policy

E-MAIL: fifield@nso1.uchc.edu

PHONE: 860/679-3815

Brief Overview

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. The evaluation is conducted as a randomized controlled longitudinal study.

Participating Organizations

EmblemHealth; Ethel Donaghue Center for Translating Research into Practice and Policy at the University of Connecticut Health Center.

Expected or Actual Demographics of Participating Practices

OF PRACTICES: 38 enrolled and 32 actively engaged

NUMBER OF OVERALL PARTICIPATING PHYSICIANS: 159

RANGE OF NUMBER OF PHYSICIANS PER PRACTICE: 1-8

TYPES OF PRACTICES:

Internal Medicine

Family Medicine

HEALTH PLAN LINES OF BUSINESS INCLUDED:

Commercial

Medicare Advantage

Medicaid Managed Care

OVERALL NUMBER OF COVERED LIVES: 12,000

Practice Technology Characteristics at Start of Pilot:

ESTIMATED % OF PRACTICES WITH PRACTICE

MANAGEMENT SYSTEMS: >95%

ESTIMATED % OF PRACTICES WITH ELECTRONIC MEDICAL

RECORD: 26-50%

ESTIMATED % OF PRACTICES WITH REGISTRY SOFTWARE:

<5%

Medical Home Recognition Program:

NCQA PPC-PCMH

Practice Transformation Support (Including Technology)

Yes

FOCAL AREAS OF TRANSFORMATION:

Care Coordination
Increased Access
Information Technology (e.g., registries, patient portals)
Team Approach to Care

ADDITIONAL DESCRIPTION: Provision of practice redesign facilitators and care management staff to practices.

SERVICES OR NEW TECHNOLOGY PARTICIPATING PRACTICES HAVE ADDED AS A RESULT OF THEIR PARTICIPATION:

EHRs (but they are not a requirement)

Payment Model

THREE-PART PAYMENT MODEL: 1) Fee-for-service; (2) Care management payment—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 of the practice's population and the practice's medical homeness score as determined by the PPC-PCMH survey and supplementary questions; and (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

Randomized assignment of practices to intervention group (enhanced payment, redesign support, onsite care manager) or comparison group (participation stipend).

EVALUATOR NAME: Judith Fifield, PhD

EVALUATOR ORGANIZATION: Ethel Donaghue Center for Translating Research for Practice and Policy at the University of Connecticut Health Center (funded by The Commonwealth Fund)

TYPES OF DATA TO BE COLLECTED:

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

Cost/Efficiency—Efficiency data using medical claims to produce a practice-level calculation of savings consisting of a risk-adjusted ratio of expected to actual episode costs.
Patient Experience/Satisfaction—Patient experience data to include measures of overall satisfaction, access, physician communication, and perceived ability to self-manage.
Qualitative process evaluation data—The evaluators are collecting qualitative process evaluation data through interviews with practice physicians and staff, as well as the staff implementing the intervention.

NCQA PPC-PCMH—Practices are completing the NCQA PPC-PCMH and sharing results with the independent evaluator.

▲▲▲ NEW YORK

Hudson Valley P4P-Medical Home Project

Project Title: Hudson Valley P4P-Medical Home Project

PROJECT LOCATION: New York

REGION WITHIN STATE: Hudson Valley

Project Status: Active

Target Start Date: 01/01/2009

Pilot/Demo Length: 3+ years

Convening Entity/Project Contacts

Convening Organization Name: THINC, Inc.

CONTACT NAME: Susan Stuard

CONTACT TITLE: Executive Director

E-MAIL: sstuard@thinc.org

PHONE: 845-896-4726

ADDITIONAL CONTACT NAME: A. John Blair, MD

CONTACT TITLE: President, Taconic IPA

E-MAIL: jblair@taconicipa.com

Brief Overview

The Hudson Valley is implementing innovative programs to potentially improve quality and reduce the cost of health care delivered. First, THINC is facilitating diffusion of electronic health record (EHR) implementation in office practices of the Hudson Valley. Second, THINC RHIO is also offering a strategic approach to pay for performance (P4P) and medical home implementation among payers and providers across the Hudson Valley that will serve as a model for New York State. The THINC P4P-Medical Home 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, the THINC P4P project will provide an

added financial incentive for private practice physicians who implement and reach Level 2 of Physician Practice Connections-Patient Centered Medical Home (PPC-PCMH), NCQA's national recognition system for physician practices.

Participating Organizations

Aetna; CDPHP; MVP; WellPoint; United; Hudson Health Plan; IBM; Taconic IPA; MassPro; ViPS; Weill Cornell Medical College.

How have you involved the consumer in the development and implementation of your demonstration?

Consumer organization input incorporated in evaluation process

Expected or Actual Demographics of Participating Practices

OF PRACTICES: 50

NUMBER OF OVERALL PARTICIPATING PHYSICIANS: 500

RANGE OF NUMBER OF PHYSICIANS PER PRACTICE: solo to 100+

TYPES OF PRACTICES:

Internal Medicine
Family Medicine
Pediatrics

HEALTH PLAN LINES OF BUSINESS INCLUDED:

Commercial
Other
OTHER: ASO

OVERALL NUMBER OF COVERED LIVES: Approximately 60 percent of commercial covered lives

Practice Technology Characteristics at Start of Pilot:

ESTIMATED % OF PRACTICES WITH PRACTICE MANAGEMENT SYSTEMS: >95%

ESTIMATED % OF PRACTICES WITH ELECTRONIC MEDICAL RECORD: >95%

ESTIMATED % OF PRACTICES WITH REGISTRY SOFTWARE: >95%

Medical Home Recognition Program:

NCQA PPC-PCMH

Practice Transformation Support (Including Technology)

Yes

FOCAL AREAS OF TRANSFORMATION:

Care Coordination

Increased Access

Information Technology (e.g., registries, patient portals)

Team Approach to Care

Payment Model

Practices in the medical home group will be eligible to receive incentive payments for achievement of NCQA Level 2 medical home recognition. All physicians will be eligible for P4P incentives.

Project Evaluation

Yes

EVALUATOR NAME: Lisa Kern, MD, MPH and Rainu Kaushal, MD, MPH

EVALUATOR ORGANIZATION: Weill Cornell Medical College

TYPES OF DATA TO BE COLLECTED:

Clinical Quality

Cost/Efficiency

Patient Experience/Satisfaction

Provider Experience/Satisfaction

ARE THE PRACTICES INVOLVED IN THE DEMONSTRATION PARTICIPATING IN ANY DATA SHARING ARRANGEMENTS?

Yes

IF SO, WITH WHOM ARE THE PRACTICES EXCHANGING DATA (EITHER THROUGH FORMAL OR INFORMAL AGREEMENTS)?

Other demonstration practices

Results to Share

In quarter 1, 2010, we should know status of first group of 215 physicians seeking to achieve Level 2 medical home.

State-by-State Guide



Greater Cincinnati Aligning Forces for Quality Medical Home Pilot

Project Title: Greater Cincinnati Aligning Forces for Quality Medical Home Pilot

PROJECT LOCATION: Ohio/Kentucky

REGION WITHIN STATE: Greater Cincinnati

Project Status: Active

TARGET START DATE: 09/12/2009

PILOT/DEMO LENGTH: 2-3 years

Convening Entity/Project Contacts

CONVENING ORGANIZATION NAME: Health

Improvement Collaborative of Greater Cincinnati

CONTACT NAME: Robert Graham, MD

CONTACT TITLE: AF4Q PCMH Chair

E-MAIL: grahamj3@fammed.uc.edu

PHONE: 513/558-5004

ADDITIONAL CONTACT NAME: Craig Brammer

CONTACT TITLE: AF4Q Project Director

E-MAIL: craig.brammer@uc.edu

PHONE: 513/558-2772

Brief Overview

Evaluating the effectiveness of the PCMH.

Participating Organizations

Health Improvement Collaborative of Greater Cincinnati; UnitedHealthCare; Anthem (WellPoint); Humana; HealthBridge; multiple primary care provider groups.

Expected or Actual Demographics of Participating Practices

OF PRACTICES: 11

NUMBER OF OVERALL PARTICIPATING PHYSICIANS: 35

RANGE OF NUMBER OF PHYSICIANS PER PRACTICE: 1-6

TYPES OF PRACTICES:

Internal Medicine

Family Medicine

HEALTH PLAN LINES OF BUSINESS INCLUDED:

Commercial

Medicare Advantage

Other: ASO

OVERALL NUMBER OF COVERED LIVES: 30,000

Practice Technology Characteristics at Start of Pilot:

ESTIMATED % OF PRACTICES WITH PRACTICE

MANAGEMENT SYSTEMS: Unknown

ESTIMATED % OF PRACTICES WITH ELECTRONIC MEDICAL

RECORD: 76-95%

ESTIMATED % OF PRACTICES WITH REGISTRY SOFTWARE:

Unknown

Medical Home Recognition Program:

NCQA PPC-PCMH

Practice Transformation Support (Including Technology)

Yes

FOCAL AREAS OF TRANSFORMATION:

TransforMED "virtual" TA

Payment Model

Fee-for-service, care management fee, and quality incentive.

Project Evaluation

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

EVALUATOR NAME: Meredith Rosenthal, PhD

Evaluator Organization: Harvard School of Public Health

TYPES OF DATA TO BE COLLECTED:

Clinical Quality

Cost/Efficiency

Patient Experience/Satisfaction

Provider Experience/Satisfaction

ARE THE PRACTICES INVOLVED IN THE DEMONSTRATION PARTICIPATING IN ANY DATA SHARING ARRANGEMENTS?

Yes

IF SO, WITH WHOM ARE THE PRACTICES EXCHANGING DATA (EITHER THROUGH FORMAL OR INFORMAL AGREEMENTS)?

Health insurance providers involved in the demonstration

Demonstration project convening organization

Practice transformation consultant(s)

WHICH OF THE DATA TYPES ARE BEING SHARED?

Clinical and quality/performance

State-by-State Guide



Queen City Physicians/Humana Patient-Centered Medical Home

Project Title: Queen City Physicians/
Humana Patient-Centered Medical Home
PROJECT LOCATION: Ohio
REGION WITHIN STATE: Cincinnati

Project Status: Active
TARGET START DATE: 12/01/2008
PILOT/DEMO LENGTH: 1.5-2 years

Convening Entity/Project Contacts
CONVENING ORGANIZATION NAME: Humana

CONTACT NAME: Chris Corbin
CONTACT TITLE: Program Manager, Humana
E-MAIL: ccorbin@humana.com
PHONE: 502/580-3820

ADDITIONAL CONTACT NAME: Pamela Coyle-Toerner
CONTACT TITLE: CEO
E-MAIL: Pamela_Coyle-Toerner@trihealth.com
PHONE: 513/246-8030

Brief Overview

Continue to evaluate the PCMH model of care and the impact on outcomes, quality and cost for members in commercial and Medicare Advantage products. We will be evaluating the performance and success of the project on key clinical, financial, satisfaction, and patient-centeredness measures. The evaluation focuses on a comparison of quarterly data with baseline data for both the test group and the control group.

Participating Organizations

Humana, Inc; Queen City Physicians.

Expected or Actual Demographics of Participating Practices

OF PRACTICES: 4

NUMBER OF OVERALL PARTICIPATING PHYSICIANS: 18

RANGE OF NUMBER OF PHYSICIANS PER PRACTICE: 4-5

TYPES OF PRACTICES:

Internal Medicine

HEALTH PLAN LINES OF BUSINESS INCLUDED:

Commercial

Medicare Advantage

OVERALL NUMBER OF COVERED LIVES: 5,200

Practice Technology Characteristics at Start of Pilot:

ESTIMATED % OF PRACTICES WITH PRACTICE MANAGEMENT SYSTEMS: >95%

ESTIMATED % OF PRACTICES WITH ELECTRONIC MEDICAL RECORD: >95%

ESTIMATED % OF PRACTICES WITH REGISTRY SOFTWARE: Unknown

Medical Home Recognition Program:

NCCA PPC-PCMH

Practice Transformation Support (Including Technology)

Yes

FOCAL AREAS OF TRANSFORMATION:

Care Coordination
Increased Access
Information Technology (e.g., registries, patient portals)
Team Approach to Care

ADDITIONAL DESCRIPTION: The practice transformation will be internally led by practices.

SERVICES OR NEW TECHNOLOGY PARTICIPATING PRACTICES HAVE ADDED AS A RESULT OF THEIR PARTICIPATION:

Diabetes education and clinical pharmacist

Payment Model

Additional care coordination payment

Project Evaluation

Ongoing and regular analysis of practice performance to practice baseline data and comparison to patient control group performance to control group baseline.

EVALUATOR ORGANIZATION: Humana

TYPES OF DATA TO BE COLLECTED:

Clinical Quality
Cost/Efficiency
Patient Experience/Satisfaction
Patient Centeredness

ARE THE PRACTICES INVOLVED IN THE DEMONSTRATION PARTICIPATING IN ANY DATA SHARING ARRANGEMENTS?

Yes

IF SO, WITH WHOM ARE THE PRACTICES EXCHANGING DATA (EITHER THROUGH FORMAL OR INFORMAL AGREEMENTS)?

Health insurance providers involved in the demonstration

WHICH OF THE DATA TYPES ARE BEING SHARED?

Clinical, quality, cost and satisfaction data

Relevant Links

www.queencityphysicians.net

Results to Share

Improvement in key diabetes indicators, reduction in key and overall medical expenses.

State-by-State Guide



TriHealth Physician Practices/Humana Patient-Centered Medical Home

Project Title: TriHealth Physician Practices/Humana Patient-Centered Medical Home
PROJECT LOCATION: Ohio
REGION WITHIN STATE: Cincinnati

Project Status: Active
Target Start Date: 05/01/2009
Pilot/Demo Length: 1.5-2 years

Convening Entity/Project Contacts
CONVENING ORGANIZATION NAME: Humana

CONTACT NAME: Chris Corbin
CONTACT TITLE: Program Manager, Humana
E-MAIL: ccorbin@humana.com
PHONE: 502/580-3820

ADDITIONAL CONTACT NAME: Vesta Johns
CONTACT TITLE: COO, TriHealth Physician Practices
E-MAIL: Vesta_Johns@trihealth.com
PHONE: 513/569-6315

Brief Overview

Continue to evaluate the PCMH model of care and the impact on outcomes, quality and cost for commercial and Medicare Advantage members. We will be evaluating the performance and success of the project on key clinical, financial, satisfaction and patient-centeredness measures. The evaluation focuses on a comparison of quarterly data with baseline data for both the test group and the control group.

Participating Organizations

Humana, Inc; TriHealth Physician Practices.

Expected or Actual Demographics of Participating Practices

OF PRACTICES: 1

NUMBER OF OVERALL PARTICIPATING PHYSICIANS: 8

RANGE OF NUMBER OF PHYSICIANS PER PRACTICE: 8

TYPES OF PRACTICES:

Internal Medicine

HEALTH PLAN LINES OF BUSINESS INCLUDED:

Commercial

Medicare Advantage

OVERALL NUMBER OF COVERED LIVES: 1100

Practice Technology Characteristics at Start of Pilot:

ESTIMATED % OF PRACTICES WITH PRACTICE MANAGEMENT SYSTEMS: >95%

ESTIMATED % OF PRACTICES WITH ELECTRONIC MEDICAL RECORD: >95%

ESTIMATED % OF PRACTICES WITH REGISTRY SOFTWARE: Unknown

Medical Home Recognition Program:

NCCA PPC-PCMH

Practice Transformation Support (Including Technology)

Yes

FOCAL AREAS OF TRANSFORMATION:

Care Coordination
Increased Access
Information Technology (e.g., registries, patient portals)
Team Approach to Care

ADDITIONAL DESCRIPTION: Practice transformation is internally led by practices.

Payment Model

Additional care coordination payment

Project Evaluation

Ongoing and regular analysis of practice performance to practice baseline data and comparison to patient control group performance to control group baseline.

EVALUATOR ORGANIZATION: Humana

TYPES OF DATA TO BE COLLECTED:

Clinical Quality
Cost/Efficiency
Patient Experience/Satisfaction
Provider Experience/Satisfaction
Patient Centeredness

ARE THE PRACTICES INVOLVED IN THE DEMONSTRATION PARTICIPATING IN ANY DATA SHARING ARRANGEMENTS?

Yes

IF SO, WITH WHOM ARE THE PRACTICES EXCHANGING DATA (EITHER THROUGH FORMAL OR INFORMAL AGREEMENTS)?

Health insurance providers involved in the demonstration

WHICH OF THE DATA TYPES ARE BEING SHARED?

Clinical, quality, cost, and satisfaction data

Relevant Links

www.trihealth.com

▲ OKLAHOMA

OU School of Community Medicine—Patient-Centered Medical Home Project

Project Title: OU School of Community Medicine—Patient-Centered Medical Home Project
PROJECT LOCATION: Oklahoma
REGION WITHIN STATE: Tulsa—North Eastern Oklahoma

Project Status: Active
TARGET START DATE: 09/30/2008
PILOT/DEMO LENGTH: 3+ years

Convening Entity/Project Contacts

CONVENING ORGANIZATION NAME: Oklahoma Health Care Authority (Medicaid) payor

CONTACT NAME: F. Daniel Duffy, MD, MACP
CONTACT TITLE: Senior Associate Dean for Academic Programs
E-MAIL: daniel-duffy@ouhsc.edu
PHONE: 918/660-3095

ADDITIONAL CONTACT NAME: Kim Johnson
CONTACT TITLE: Senior Project Manager for the PCMH
E-MAIL: kim-johnson@ouhsc.edu

Brief Overview

The project is designed to transform the teaching clinics of the University of Oklahoma School of Community Medicine into the PCMH. This pilot was initiated in response to the Oklahoma Health Care Authority's (Medicaid) change from pure capitation to fee-for-service plus a capitated fee for care management. OU intends to shape its teaching clinics on the medical home model. We wish to demonstrate that patients will have better access to primary and specialty care, increased access to medical advice, more efficient and effective treatment for chronic care, improved support and education for meaningful lifestyle changes and

proactive, holistic health care instead of reactive responses to symptoms. The Tulsa and Northeast Oklahoma community will benefit by having fewer ER admissions for acute primary care, fewer relapses of chronic conditions, and improved mental and physical health-related behaviors that will result in better overall health trends. OU Physicians practices will provide proactive instead of reactive care, form integrated health care teams, improve communications between care teams, prevent conflicting treatment plans or missed services, and permit all professionals to practice at the top of their license.

Participating Organizations

University of Oklahoma School of Community Medicine; Oklahoma Health Care Authority.

Expected or Actual Demographics of Participating Practices

OF PRACTICES: 4

TYPES OF PRACTICES:

Internal Medicine
Family Medicine
Pediatrics

HEALTH PLAN LINES OF BUSINESS INCLUDED:

Medicaid Managed Care

OVERALL NUMBER OF COVERED LIVES: 30,000

Practice Technology Characteristics at Start of Pilot:

ESTIMATED % OF PRACTICES WITH PRACTICE MANAGEMENT SYSTEMS: >95%

ESTIMATED % OF PRACTICES WITH ELECTRONIC MEDICAL RECORD: >95%

ESTIMATED % OF PRACTICES WITH REGISTRY SOFTWARE: <5%

OTHER: Consultation and referral software

Medical Home Recognition Program:

Oklahoma Health Care Authority designation of medical home tier level

Practice Transformation Support (Including Technology)

Yes

FOCAL AREAS OF TRANSFORMATION:

Care Coordination

Increased Access

Information Technology (e.g., registries, patient portals)

Team Approach to Care

ADDITIONAL DESCRIPTION: Intensive project management support with timelines and modeling of practice work flow with improvement processes.

SERVICES OR NEW TECHNOLOGY PARTICIPATING PRACTICES HAVE ADDED AS A RESULT OF THEIR PARTICIPATION:

More effective use of EMR for decision support, screening for mental and behavioral health problems, electronic submission of consultations and referral requests, addition of social workers to provide care coordination.

Payment Model

Fee for service payments are provided for services delivered by participating practices. An additional payment for care management will be paid on a per member per month basis according to the medical home tier designation. An additional payment for the Health Access Network of practices will be paid when the waiver has been obtained.

Project Evaluation

There is a monthly analysis of the progress for each practice advancement towards meeting the targets for implementing Tier 3 requirements. The time spent, cost of the implementation, and the increase in patient contacts, revenues, and services is being tracked.

EVALUATOR NAME: Kim Johnson

EVALUATOR ORGANIZATION: OU School of Community Medicine

TYPES OF DATA TO BE COLLECTED:

Clinical Quality

Cost/Efficiency

Patient Experience/Satisfaction

Provider Experience/Satisfaction

The routine collection of clinical measures for well child examinations, preventive services, and chronic illness processes (diabetes, asthma) are planned to be collected over the course of the pilot. Every six months patient and staff satisfaction measures are being collected. Monthly reports of practice cost and efficiency are reported.

Relevant Links

<http://tulsa.ou.edu/docs/index.htm> <http://tulsa.ou.edu/socm/action.htm#1>



Results to Share

Yes. All of the practices have assigned patients to physician directed care teams. Health risk appraisals, mental and behavioral health screening has begun. Proactive contact of patients for screening and chronic illness care has started. A PCMH patient-provider contract has been initiated. The EMR forms have been re-designed to incorporate the principles of organized data collection for the medical home. Outbound calls have been initiated to engage patients in their own care.

PENNSYLVANIA

Pennsylvania Chronic Care Initiative

Project Title: Pennsylvania Chronic Care Initiative

PROJECT LOCATION: Pennsylvania

Project Status: Active

TARGET START DATE: 05/13/2008

PILOT/DEMO LENGTH: 3+ years

Convening Entity/Project Contacts

CONVENING ORGANIZATION NAME: Governor's Office of Health Care Reform

CONTACT NAME: Philip Magistro

CONTACT TITLE: Deputy Director

E-MAIL: pmagistro@state.pa.us

PHONE: 717/214-8174

ADDITIONAL CONTACT NAME: Michael Bailit

CONTACT TITLE: Consultant

E-MAIL: mbailit@bailit-health.org

PHONE: 781/453-1166

Brief Overview

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 PCMH standards as a validation tool that practices are transforming their care delivery to effectively manage chronically ill patients. There are seven regional learning collaboratives underway across the Commonwealth.

Participating Organizations

Governor's Office of Health Care Reform; Aetna; AmeriChoice; AmeriHealth Mercy; Capital Blue Cross; Geisinger Health Plan; Health Partners; Keystone Mercy; Highmark BC/BS; Independence Blue Cross; Northeast PA Blue Cross; Unison; University of Pittsburgh Health Plan; University of Pennsylvania Health System; Jefferson Health System; American Board of Internal Medicine; American College of Physicians; Pennsylvania Association of Family Physicians; Improving Performance in Practice (IPIP); Pennsylvania Department of Public Welfare.

How have you involved the consumer in the development and implementation of your demonstration?

Consumer organization input incorporated in the project design process and in evaluation process

Expected or Actual Demographics of Participating Practices

OF PRACTICES: 170

NUMBER OF OVERALL PARTICIPATING PHYSICIANS: 780

RANGE OF NUMBER OF PHYSICIANS PER PRACTICE: 1-10

TYPES OF PRACTICES:

Internal Medicine
Family Medicine
Pediatrics

HEALTH PLAN LINES OF BUSINESS INCLUDED:

Commercial
Medicare Advantage
Medicaid Managed Care

OVERALL NUMBER OF COVERED LIVES: 1,093,246

Practice Technology Characteristics at Start of Pilot:

ESTIMATED % OF PRACTICES WITH PRACTICE MANAGEMENT SYSTEMS: >95%

ESTIMATED % OF PRACTICES WITH ELECTRONIC MEDICAL RECORD: 51-75%

ESTIMATED % OF PRACTICES WITH REGISTRY SOFTWARE: 26-50%

Medical Home Recognition Program:

NCQA PPC-PCMH

Practice Transformation Support (Including Technology)

Yes

FOCAL AREAS OF TRANSFORMATION:

Care Coordination

Increased Access

Information Technology (e.g., registries, patient portals)

New Pay for Performance Models

Team Approach to Care

Other: Implementing all aspects of the Chronic Care Model.

ADDITIONAL DESCRIPTION: Practices submit monthly data and narrative reports. Practice coaches and a Collaborative Quality Improvement Director support the transformation of the practices.

SERVICES OR NEW TECHNOLOGY PARTICIPATING PRACTICES HAVE ADDED AS A RESULT OF THEIR PARTICIPATION:

A Web-based patient registry is available to practices that do not have an electronic medical record or that have an EMR without registry functions.

Payment Model

There are payments to the practices to help offset practice management costs, the cost of hiring or contracting for care management, and incentives to achieve Level 1 Plus, Level 2, and Level 3 recognition in the PCMH standards. There is also a shared savings payment of up to 50 percent based on performance to identified measures.

Project Evaluation

Yes

TYPES OF DATA TO BE COLLECTED:

Clinical Quality

Cost/Efficiency

Patient Experience/Satisfaction

Provider Experience/Satisfaction

ARE THE PRACTICES INVOLVED IN THE DEMONSTRATION PARTICIPATING IN ANY DATA SHARING ARRANGEMENTS?

Yes

IF SO, WITH WHOM ARE THE PRACTICES EXCHANGING DATA (EITHER THROUGH FORMAL OR INFORMAL AGREEMENTS)?

Practice transformation consultant(s)



MULTI-STAKEHOLDER

WHICH OF THE DATA TYPES ARE BEING SHARED?

Clinical data, quality measures

Relevant Links

<http://www.rxfopa.com/chroniccare.html>

RHODE ISLAND

Rhode Island Chronic Care Sustainability Initiative

Project Title: Rhode Island Chronic Care Sustainability Initiative

PROJECT LOCATION: Rhode Island

Project Status: Active

TARGET START DATE: 10/01/2008

PILOT/DEMO LENGTH: 2-3 years

Convening Entity/Project Contacts

CONVENING ORGANIZATION NAME: RI Office of the Health Insurance Commissioner

CONTACT NAME: Deidre S. Gifford, MD, MPH

CONTACT TITLE: Project Director

E-MAIL: Deidre_Gifford@brown.edu

PHONE: 401/487-0929

Brief Overview

The Rhode Island PCMH demonstration is convened by the RI Office of the Health Insurance Commissioner. It was developed and is overseen by a broad multi-stakeholder coalition. All Rhode Island payers except FFS Medicare are participating. The pilot began in October 2008. In addition to existing FFS schedules, pilot sites receive a per-member per month fee for every member of their practice, based on an attribution methodology that is standardized across commercial payers. In addition, pilot sites are reimbursed by the health plans for the services of a nurse care manager, who is employed by the practice, based in the practice, and sees patients of any and all insurers. As a condition of participation, practices and care managers have received training through the RI Department of Health and RI Quality Improvement Organization. Practices report quarterly from an EMR or electronic registry on clinical measures for diabetes, coronary artery disease, and

depression. All pilot sites have received Level 1 PCMH recognition from NCQA as of July 2009. Practices must achieve Level 2 recognition after 18 months of pilot participation.

Participating Organizations

RI Office of the Health Insurance Commissioner; RI Department of Health; RI Department of Human Services; Blue Cross and Blue Shield of Rhode Island; United Health Care–New England; Neighborhood Health Plan of Rhode Island; Tufts Health Plan; Health Progress; Quality Partners of Rhode Island; Coastal Medical Group; University Medicine Foundation–Governor St. Primary Care Center; Hillside Family and Community Medicine; Family Health and Sports Medicine; Thundermist Health Center; Rhode Island Health Center Association; Lifespan Health System; Care New England; Brown Medical School Dept. of Family Medicine; RI State Employees Purchasing Program.

How have you involved the consumer in the development and implementation of your demonstration?

Consumer organization input incorporated in the project design process

Expected or Actual Demographics of Participating Practices

OF PRACTICES: 5

NUMBER OF OVERALL PARTICIPATING PHYSICIANS: 28

RANGE OF NUMBER OF PHYSICIANS PER PRACTICE: 3-8

TYPES OF PRACTICES:

Internal Medicine

Family Medicine

OTHER: Federally Qualified Health Center

HEALTH PLAN LINES OF BUSINESS INCLUDED:

Commercial

Medicare Advantage

Medicaid Managed Care

OTHER: Medicaid PCCM

OVERALL NUMBER OF COVERED LIVES: 28,000

Practice Technology Characteristics at Start of Pilot:

ESTIMATED % OF PRACTICES WITH PRACTICE MANAGEMENT SYSTEMS: >95%

ESTIMATED % OF PRACTICES WITH ELECTRONIC MEDICAL RECORD: 76-95%

ESTIMATED % OF PRACTICES WITH REGISTRY SOFTWARE: >95%

Medical Home Recognition Program:

NCQA PPC-PCMH

Practice Transformation Support (Including Technology)

Yes

FOCAL AREAS OF TRANSFORMATION:

Care Coordination

Information Technology (e.g., registries, patient portals)

Team Approach to Care

OTHER: Training model is based on breakthrough series collaborative and chronic care models.

ADDITIONAL DESCRIPTION: All practice members are included in training programs. In addition to the collaborative training, nurse care managers from pilot practices are brought together regularly for additional training and support.

SERVICES OR NEW TECHNOLOGY PARTICIPATING PRACTICES HAVE ADDED AS A RESULT OF THEIR PARTICIPATION:

Practices have upgraded the functionalities of the EMRs to collect and monitor quality data, to imbed evidence-based guidelines, and to provide prompts and reminders at the point of care. One practice has implemented a stand-alone registry. Staff that have been added include a new position, the "quality assistant" who is responsible for collecting, distributing, and monitoring quality measures. Nurse care managers in all sites work on self-management support, quality measurement and improvement, and care coordination activities.

Payment Model

Practices receive \$3 per member per month for all members covered by participating insurers. They receive additional reimbursement for salary and benefits of the nurse care manager.

Project Evaluation

Effects of the pilot on quality, cost, and patient and provider experience will be measured and compared to control practices.

EVALUATOR NAME: Meredith Rosenthal, PhD

EVALUATOR ORGANIZATION: Harvard School of Public Health

TYPES OF DATA TO BE COLLECTED:

Clinical Quality

Cost/Efficiency

Patient Experience/Satisfaction

Provider Experience/Satisfaction

Cost and quality measures will be based on claims data.

Structured interviews and surveys of providers will provide data on provider experience/satisfaction, and a patient experience survey at the conclusion of the pilot will measure patient satisfaction.

ARE THE PRACTICES INVOLVED IN THE DEMONSTRATION PARTICIPATING IN ANY DATA SHARING ARRANGEMENTS?

Yes. Practices report clinical quality data quarterly. The data are reviewed by the stakeholder coalition, and provide the basis for on-going evaluation of the program.

IF SO, WITH WHOM ARE THE PRACTICES EXCHANGING DATA (EITHER THROUGH FORMAL OR INFORMAL AGREEMENTS)?

Other demonstration practices

Health insurance providers involved in the demonstration

Demonstration project convening organization

Practice transformation consultant(s)

WHICH OF THE DATA TYPES ARE BEING SHARED?

Clinical quality data for diabetes, coronary artery disease, and depression are reported by the practices from an EMR or registry. Health plans are providing coordinated reports to practices regarding inpatient hospitalization and emergency department use.

Results to Share

Sample of self-reported clinical quality improvement in the first nine months of program (all sites combined): diabetes patients with a documented hemoglobin A1c: 64% baseline, 72% Quarter 2; diabetes patients with BP <130/80: 18% baseline, 30% Quarter 2; CAD patients on Beta blocker: 40% baseline, 65% Quarter 2; smokers with documented advice to quit: 14% baseline, 35% Quarter 2. Results of the formal program evaluation will not be available until the end of the 2-year pilot period, in early 2011.

TEXAS

Texas Medical Home Initiative

Project Title: Texas Medical Home Initiative

Project Location: Texas

REGION WITHIN STATE: North Texas (initial phase of pilot)

Project Status: Under Development

TARGET START DATE: 01/01/2010

PILOT/DEMO LENGTH: 2-3 years

Convening Entity/Project Contacts

CONVENING ORGANIZATION NAME: Texas Chapter of the ACP (to be reviewed 12/09)

CONTACT NAME: Sue Bornstein

CONTACT TITLE: Executive Director

E-MAIL: suebornstein@gmail.com

PHONE: 214/709-7642

Brief Overview

The project attempts to facilitate increased clinical quality and efficiency, improved patient and physician experience of care, and overall care coordination and integration within and among the participating practices. The project will begin with a small scale implementation. Based upon “lessons learned” during the first 12-18 months of this implementation, the project will be expanded. During Stage One, the focus will be primarily on adults; however, the project will also include patients younger than 18 with severe asthma. In addition, there will be a focus on young adults with special health care needs aged 14-24 if transferring from pediatric practices. Stage One will be limited to practices that treat adult patients or both child and adult patients in which the medical home team leader is a primary care physician within one of three practice types: one large primary care practice, two small to medium (2-7 practitioners) primary care practices or one multi-specialty

and/or integrated practice. Selected practices will have a six month “ramp up” period to achieve the qualifications required to initiate payment:

- NCQA Level 1 recognition
- 24 hour/7 day access
- Establishment of a patient registry
- Implementation of evidence-based protocols
- Establishment of service agreements with defined specialty practices and at least one frequently referred-to hospital
- Agreement to assist in providing relevant patient claims and defined additional clinical information to the TMHI project
- Participation in the special needs transition program.

Participating Organizations

Texas Chapter ACP; Texas Academy of Family Physicians; Texas Pediatrics Society; Texas Medical Association; American College of Physicians; State Department of Health; Office of Medical Director–Texas Medicaid; Aetna; Blue Cross Blue Shield; CIGNA; Employee Retirement System of Texas; Humana; United Healthcare; IBM.

How have you involved consumer in the development and implementation of your demonstration?

Consumers and family members are involved in the pilot as members of task forces, members of advisory committees and consumer advocates.

Expected or Actual Demographics of Participating Practices

OF PRACTICES: 3-5

NUMBER OF OVERALL PARTICIPATING PHYSICIANS: 30-40

MULTI-STAKEHOLDER

RANGE OF NUMBER OF PHYSICIANS PER PRACTICE: 2-10

TYPES OF PRACTICES:

Internal Medicine
Family Medicine

HEALTH PLAN LINES OF BUSINESS INCLUDED:

Commercial

OVERALL NUMBER OF COVERED LIVES: 20-30,000

Medical Home Recognition Program:

NCQA PPC-PCMH

COMMENTS: We will utilize the NCQA PPC-PCMH recognition process. However, we will add elements to this process including development of a medical neighborhood and transition of young adults with special health care needs.

**Practice Transformation Support
(Including Technology)**

Yes

FOCAL AREAS OF TRANSFORMATION:

Care Coordination
Increased Access
Information Technology (e.g., registries, patient portals)
New Pay for Performance Models
Team Approach to Care

ADDITIONAL DESCRIPTION: The transformation is internally led by clinics.

PROJECT EVALUATION

Under development.

EVALUATOR NAME: Mark Friedberg, MD, MPH

TYPES OF DATA TO BE COLLECTED:

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

VERMONT

Vermont Blueprint Integrated Pilot Program

Project Title: Vermont Blueprint Integrated Pilot Program

PROJECT LOCATION: Vermont

Project Status: Active

Staggered start dates for the three pilot sites—

7/08, 10/08 and 11/09

TARGET START DATE: 07/01/2008

PILOT/DEMO LENGTH: 2-3 years

Convening Entity/Project Contacts

CONVENING ORGANIZATION NAME: Vermont

Department of Health

CONTACT NAME: Lisa Dulsky Watkins, MD

CONTACT TITLE: Associate Director, Vermont Blueprint for Health

E-MAIL: lwatkin@vdh.state.vt.us

PHONE: 802/652-2095

Brief Overview

The State of Vermont, under the auspices of a true public-private partnership, has established an innovative program called the Blueprint for Health. The Blueprint is guiding a comprehensive and statewide process of transformation designed to reduce the health and economic impact of the most common chronic conditions and focus on their prevention. The Blueprint is helping primary care providers operate their practices as patient-centered medical homes, offering well-coordinated care supported by local multidisciplinary teams, expanding use of Health IT, and assisting the development of a statewide health information exchange network and financial reform that sustains these processes and aligns fiscal incentives with health care goals. This high level of care incorporates strategies to enhance self management and is closely

integrated with community-wide public health and prevention efforts. The care coordination team, known as the Community Health Team (CHT) is a multidisciplinary group that partners with primary care offices, the hospital, and existing health and social service organizations to create, monitor, and evaluate a holistic community care coordination system in their service area. Services are free to all patients (no eligibility requirements), and the pilot is financed as a shared resource by Vermont's major commercial and public payers.

Participating Organizations

Vermont Governor, James Douglas; Vermont State Legislature; Office of Vermont Health Access (VT Medicaid); Banking, Insurance, Securities and Health Care Agency; BCBSVT; MVP Health Plan; CIGNA; University of Vermont College of Medicine; Dartmouth Institute of Health Policy and Clinical Practice; Vermont Program for Quality in Health Care; Vermont Information Technology Leaders; Vermont Association of Hospitals and Health Systems; Vermont Medical Society; Vermont State Employees Association; IBM; Northeast Vermont Regional Hospital; Northern Counties Health Care; Fletcher Allen Health Care; Southwestern Vermont Medical Center; Central Vermont Medical Center; Mt. Ascutney Hospital; Springfield Hospital; IHI; AcademyHealth; Commonwealth Fund; Brookings Institution; Milbank Memorial Fund; AHRQ; PCPCC).

How have you involved the consumer in the development and implementation of your demonstration?

Individual consumer surveys and focus groups as part of the evaluation. Consumers have also been involved as mentors for other patients and group facilitators.

Expected or Actual Demographics of Participating Practices

OF PRACTICES: 14

NUMBER OF OVERALL PARTICIPATING PHYSICIANS:

44 physicians, 23 mid-levels

RANGE OF NUMBER OF PHYSICIANS PER PRACTICE:

1–10 physicians, 1–12 primary care providers

TYPES OF PRACTICES:

Internal Medicine

Family Medicine

HEALTH PLAN LINES OF BUSINESS INCLUDED:

Commercial

Medicare Advantage

Medicaid Managed Care

OVERALL NUMBER OF COVERED LIVES: 60,000

Practice Technology Characteristics at Start of Pilot:

ESTIMATED % OF PRACTICES WITH PRACTICE MANAGEMENT SYSTEMS: >95%

ESTIMATED % OF PRACTICES WITH ELECTRONIC MEDICAL RECORD: 51-75%

ESTIMATED % OF PRACTICES WITH REGISTRY SOFTWARE: 51-75%

OTHER: Wide range of capacity from paper to integrated EMR with registry.

Medical Home Recognition Program:

NCQA PPC-PCMH

Practice Transformation Support (Including Technology)

Yes

FOCAL AREAS OF TRANSFORMATION:

Care Coordination

Increased Access

Information Technology (e.g., registries, patient portals)

New pay for performance models

Team Approach to Care

OTHER: Access to care coordination team WITHOUT cost to either the practice or the patient

ADDITIONAL DESCRIPTION: The Blueprint is helping primary care providers operate their practices as PCMHs, offering well-coordinated care supported by local multidisciplinary teams and financial reform that sustains these processes and aligns fiscal incentives with health care goals. This high level of care incorporates strategies to enhance self management and is closely integrated with community-wide prevention efforts. It is based on a model that is designed to be financially sustainable, scalable, and replicable. The transformational activity is internally led by clinics.

SERVICES OR NEW TECHNOLOGY PARTICIPATING PRACTICES HAVE ADDED AS A RESULT OF THEIR PARTICIPATION:

The Blueprint is helping by offering expanded use of health information technology, assisting the development of a statewide health information exchange network, and offering at no cost the DocSite Web-based clinical tracking system. This can be used either directly or via an interface with the practice's existing EMR.

Payment Model

Practices participating in the integrated pilots are provided with the care coordination infrastructure and financial incentives to operate a PCMH. The pilot practices are provided with enhanced payment through Vermont's private insurers and Medicaid based on meeting nationally recognized quality standards and integration of local Community Health Teams (CHT) into clinical practice. This Blueprint-initiated payment reform ensures the program's sustainability.

Project Evaluation

Multi-level evaluation from a variety of sources including patients, providers, clinic staff, clinical data, health plans, and the community.

EVALUATOR NAME: Jennifer Hicks, Julianne Krulewitz, Charles MacLean, Greg Peters

EVALUATOR ORGANIZATION: Vermont Department of Health, University of Vermont, Lake Champlain Capital Management

TYPES OF DATA TO BE COLLECTED:

Clinical Quality
Cost/Efficiency
Patient Experience/Satisfaction
Provider Experience/Satisfaction
Direct chart review, registry, multi-payer claims data base, public health sources (i.e., BRFSS, hospital discharge and disease prevalence data and immunization registry), qualitative collection (e.g., patient, provider surveys and focus groups)

ARE THE PRACTICES INVOLVED IN THE DEMONSTRATION PARTICIPATING IN ANY DATA SHARING ARRANGEMENTS?

Yes. Practices will be able to compare themselves in a de-identified manner to other organizations via the Blueprint evaluation process.

IF SO, WITH WHOM ARE THE PRACTICES EXCHANGING DATA (EITHER THROUGH FORMAL OR INFORMAL AGREEMENTS)?

Demonstration project convening organization

WHICH OF THE DATA TYPES ARE BEING SHARED?

Clinical outcomes, process measures, resource utilization.

Relevant Links

Blueprint Web site:

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

2009 Blueprint Annual Report:

<http://healthvermont.gov/admin/legislature/documents/BlueprintAnnualReport0109.pdf>

Results to Share

We have preliminary information about the program. The 2010 Annual Report will contain information about the Integrated Pilot Program progress, with a full evaluation document (clinical and financial efficacy) due out in the next year.

▲ WEST VIRGINIA

West Virginia Medical Home Pilot

Project Title: West Virginia Medical Home Pilot

PROJECT LOCATION: West Virginia

Project Status: Under Development

TARGET START DATE: 11/01/2009

PILOT/DEMO LENGTH: 1.5–2 years

Convening Entity/Project Contacts

CONVENING ORGANIZATION NAME: West Virginia Health Improvement Institute

CONTACT NAME: Christine St. Andre

CONTACT TITLE: WVHII consultant staff

E-MAIL: cstandre@spreadinnovation.com

PHONE: 435/649-6439

ADDITIONAL CONTACT NAME: Carl Callison

CONTACT TITLE: Chair, WVHII Measurement Work Group

E-MAIL: carlcallison@gmail.com

Brief Overview

The pilot project is being undertaken by the WV Health Improvement Institute and is a multi-payer initiative intended to determine the impact of implementation of the medical home model on clinical outcomes and health resource utilization, and to inform possible reimbursement changes in West Virginia. The first phase of the pilot includes a six-month intense collaborative learning experience for care teams of all participating practices. Practices will receive coaching and technical assistance throughout the pilot, will apply for NCQA recognition, and will report monthly on a standard set of clinical outcomes measures. These measures, along with patient experience and utilization metrics, will be used as the basis for future incentive payments. The incentive pool will be comprised of

contributions from each of the participating payers based on savings realized in a 12-month period.

Participating Organizations

West Virginia Health Improvement Institute; WV Bureau of Medical Services (Medicaid); WV Public Employees Insurance Association; Mountain State Blue Cross; UniCare; WVCHIP; WV Academy of Family Practice; WV Academy of Pediatrics; WV Medical Institute; WV State Medical Association; WV Primary Care Association; Health Plan of Upper Ohio Valley; Coventry.

How have you involved the consumer in the development and implementation of your demonstration?

Consumer organization input incorporated in evaluation process (planned)

Expected or Actual Demographics of Participating Practices

OF PRACTICES: up to 25

NUMBER OF OVERALL PARTICIPATING PHYSICIANS: up to 50

RANGE OF NUMBER OF PHYSICIANS PER PRACTICE: 01/05/2009

TYPES OF PRACTICES:

Internal Medicine
Family Medicine
Pediatrics

HEALTH PLAN LINES OF BUSINESS INCLUDED:

Commercial
Medicaid Managed Care

OVERALL NUMBER OF COVERED LIVES: approximately 20,000

Practice Technology Characteristics at Start of Pilot:

ESTIMATED % OF PRACTICES WITH PRACTICE MANAGEMENT SYSTEMS: >95%
ESTIMATED % OF PRACTICES WITH ELECTRONIC MEDICAL RECORD: 26-50%
ESTIMATED % OF PRACTICES WITH REGISTRY SOFTWARE: 5-25%

Medical Home Recognition Program:

NCQA PPC-PCMH

Practice Transformation Support (Including Technology)

Yes

FOCAL AREAS OF TRANSFORMATION:

Care Coordination
Increased Access
Information Technology (e.g., registries, patient portals)
New Pay for Performance Models
Team Approach to Care
OTHER: general QI and process improvement approaches

ADDITIONAL DESCRIPTION: Collaborative learning experience supported by an online knowledge management system, as well as practice coaching.

Payment Model

Pilot includes an incentive system but no initial changes to ongoing reimbursement

Project Evaluation

Not yet fully planned

TYPES OF DATA TO BE COLLECTED:

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

ARE THE PRACTICES INVOLVED IN THE DEMONSTRATION PARTICIPATING IN ANY DATA SHARING ARRANGEMENTS?

Yes

COMMENTS: full transparency is part of overall pilot philosophy

IF SO, WITH WHOM ARE THE PRACTICES EXCHANGING DATA (EITHER THROUGH FORMAL OR INFORMAL AGREEMENTS)?

Other demonstration practices
Health insurance providers involved in the demonstration
Demonstration project convening organization
Practice transformation consultant(s)

WHICH OF THE DATA TYPES ARE BEING SHARED?

Clinical process and outcomes measures initially; cost/efficiency as they become available

Relevant Links

www.wvhealthimprovement.org

Proof in Practice Requires Ongoing Evaluation

By Rebecca A. Malouin, Ph.D., M.P.H.

In 2008, the Patient-Centered Primary Care Collaborative (PCPCC) Center for Multi-Stakeholder Demonstrations (CMD) published the first compilation of PCMH demonstration projects, *Patient-Centered Medical Home: Building Evidence and Momentum*. The monograph serves as a resource guide and initial point of discussion regarding various demonstrations around the country, but provides only limited information regarding the evaluation plan for and components of each demonstration. As many patient centered medical home (PCMH) demonstrations have begun, baseline data is being collected. However, the metrics or data elements collected by each project are neither widely known nor comparable in content. Understanding the type of data collected is essential to any effort to compare outcomes within and across demonstrations.

Currently, the Commonwealth Fund is funding a PCMH Evaluators' Collaborative, under the leadership of Melinda Abrams and facilitated by Meredith Rosenthal, Ph.D of Harvard University. The goals of the Evaluators' Collaborative are to: (1) reach consensus about a standard set of data collection instruments (or a portion of those instruments); (2) reach consensus about a standard, core set of outcome measures in multiple areas (clinical quality, patient experience, physician/staff experience, efficiency); (3) share the Collaborative's consensus on instruments, metrics and/or methodological lessons with interested researchers and stakeholders around the country through public venues; and (4) foster an ongoing and supportive exchange in which evaluators share ideas that improve their evaluation designs. The goal of this group is to develop standardized practices across the demonstrations.

In March 2009, the American Academy of Family Physicians, the American Academy of Pediatrics, the American College of Physicians and the American Osteopathic Association created "Guidelines for Patient Centered Medical Home (PCMH) Demonstration Projects," endorsed by the PCPCC. (http://pcpcc.net/files/pcmh_demo_guidelines.pdf) The guidelines provide a description of specific types of data to be collected, including descriptive data about patients, process and outcomes measures of clinical quality, measures of resources used, measures of patient and family experiences with care, and measures of experience of providers, staff and payers.

The CMD, through financial support from the Health Resources and Services Administration (HRSA) Maternal and Child Health Bureau (MCB) and in-kind support from the IBM Corporation, conducted a survey of PCMH demonstrations to ascertain both unique and shared data elements. The results may stimulate further discussion of the possibility of standardization of data collection instruments or core outcome metrics that could facilitate the cross-study comparisons of demonstration results in the future. The work could also support the goal of the Evaluators' Collaborative. More immediately, the results may inform demonstrations in beginning stages.

Methods

A questionnaire was developed in collaboration with Vic Toy, MPH of the IBM Corporation. The questionnaire included open-ended questions in order to capture the range of possible responses by demonstrations. The PCPCC Center for eHealth Information Adoption and Exchange also contributed two questions related to consumer use of

technology within the demonstrations. The questionnaire was programmed into Lotus software for completion online by demonstration participants. The CMD assisted in identification of demonstrations to participate in the survey using the 2008 PCPCC demonstration guide and snowball sampling through discussions with other demonstrations and PCPCC partners. From Aug. 1 to Sept. 25, 2009, 29 demonstrations were identified and subsequently invited to participate in the online survey.

Results

Nineteen demonstrations responded to the survey for a response rate of 65 percent. Twelve (63 percent) of the responding demonstrations have formal evaluation plans in place, and the remaining demonstrations are still in the process of developing plans although they were able to contribute responses to many of the survey questions. Eight (42 percent) of the demonstrations are using an external evaluator. The demonstrations ranged in size from one to 2,400 practices with a median size of nine practices. The demonstrations represent diverse geographic areas across the country, as well as both single payer and multi-stakeholder initiatives. Sixteen (84 percent) of the demonstrations report intent to include comparison practices in their evaluation design.

The results indicate the need for greater attention to and resources for rigorous evaluation of the PCMH demonstrations.

Questions were asked based on the source of data contributing to the evaluation plan, including: at the level of the patients/consumers, the providers, the clinic staff, the clinic, the health plan, the community, the multi-stakeholder collaborative, and the payer. Seventeen (89 percent) of the demonstrations are collecting data from

patients/consumers. Seventeen (89 percent) of the demonstrations are collecting information about provider experience. And 12 (63 percent) of the demonstrations are collecting information about clinic staff experience. Seventeen (89 percent) of the demonstrations are collecting clinical data from the practices.

Nine (47 percent) of the demonstrations are collecting information from the health plan(s). Six (32 percent) are collecting information from the community, although only two are actually collecting information about members outside the health plan, such as the data from community health departments. Others define the community as health plan members, not included in the demonstration, within a defined geographic area. Three (16 percent) of the demonstrations are contributing data from a multi-stakeholder collaborative to the demonstration evaluation. Only two (11 percent) of the demonstrations are including information from payers in the demonstration evaluation.

Discussion

While the response rate was not as high as anticipated, of the 19 respondents, only 12 already have evaluation plans in place. All but two of the demonstrations had already begun at the time of the initiation of the survey. Many of the respondents indicated that specific types of data would be collected (for example patient or provider experience) but were not yet able to provide specific tools or data elements that would be collected. Fewer than half of the demonstrations indicated collaboration with an external evaluator.

The results indicate the need for greater attention to and resources for rigorous evaluation of the PCMH demonstrations. Although resources are being directed to the demonstrations, absent a rigorous evaluation plan, developed before the onset of a demonstration, interpretation of the various demonstration results may be difficult if not impossible. The Commonwealth Fund, the Agency for Healthcare Research and Quality, single payer plans, and multi-stakeholder initiatives have dedicated significant resources for evaluation of the PCMH demonstrations. Clearly greater communication and collaboration across demonstrations, such as the Evaluators' Collaborative supported by the Commonwealth Fund, may assist in development of more rigorous evaluation plans.

Joint Principles

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 American Academy of Family Physicians (AAFP), American Academy of Pediatrics (AAP), American College of Physicians (ACP), American Osteopathic Association (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.
- 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
- 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

The Outcomes of Implementing Patient-Centered Medical Home Interventions: A Review of the Evidence on Quality, Access and Costs from Recent Prospective Evaluation Studies, August 2009

Prepared by Kevin Grumbach, MD, Thomas Bodenheimer, MD MPH and Paul Grundy MD, MPH

A bundant research comparing nations, states and regions within the U.S., and specific systems of care has shown that health systems built on a solid foundation of primary care deliver more effective, efficient, and equitable care than systems that fail to invest adequately in primary care.^{i, ii} However, some policy analysts have questioned whether these largely cross-sectional, observational studies are adequate for making inferences about whether implementing major policy interventions to strengthen primary care as part of health reform would in the relatively short term “bend the cost curve” at the same time as improving quality of care and patient outcomes.

Is there research using prospective, controlled study designs which shows what happens to quality, access and costs as a result of investments to enhance and improve primary care? Have recent evaluations documented the outcomes of interventions in the U.S. promoting primary care patient centered medical homes (PCMHs)?

The answer to these questions is, Yes. Although some major evaluations of the PCMH are only now getting off the ground, including the evaluation of the Medicare Medical Home Demonstrations, evaluations of other primary care initiatives are much farther along, and the findings of some of these evaluations are starting to emerge in peer-reviewed journals and other publications.

This briefing document summarizes key findings from recent PCMH evaluation studies. These studies have investigated a variety of PCMH models, in a variety of settings ranging from integrated delivery systems to

community-based office practices. Some evaluations examine interventions focused on general primary care patient populations, and others on high risk subsets. The evaluations span privately insured patients, Medicaid, SCHIP and Medicare beneficiaries, and the uninsured.

Across these diverse settings and patient populations, evaluation findings consistently indicate that investments to redesign the delivery of care around a primary care PCMH yield an excellent return on investment:

- Quality of care, patient experiences, care coordination, and access are demonstrably better.
- Investments to strengthen primary care result within a relatively short time in reductions in emergency department visits and inpatient hospitalizations that produce savings in total costs. These savings at a minimum offset the new investments in primary care in a cost-neutral manner, and in many cases appear to produce a reduction in total costs per patient.

This summary provides a review of recent PCMH evaluations. The initial section of the summary provides a concise view of the key data on cost outcomes. The subsequent section provides more information about each PCMH model and includes data on quality and access in addition to costs, as well as reference citations.

I. Summary of Key Data on Cost Outcomes from Patient Centered Medical Home Interventions

Group Health Cooperative of Puget Sound

- 29% reduction in ER visits and 11% reduction in ambulatory sensitive care admissions.
- Additional investment in primary care of \$16 per patient per year was associated with offsetting cost reductions, with the net result being no overall increase in total costs for pilot clinic patients (the total net cost trend was a savings of \$17 per patient per year, which was not statistically significant). Unpublished data from the 24 month evaluation reportedly show a statistically significant decrease in total costs.

Community Care of North Carolina

- 40% decrease in hospitalizations for asthma and 16% lower ER visit rate; total savings to the Medicaid and SCHIP programs are calculated to be \$135 million for TANF-linked populations and \$400 million for the aged, blind and disabled population.

HealthPartners Medical Group BestCare PCMH Model

- 39% decrease in emergency room visits, 24% decrease in hospital admissions
- Overall costs in the PCMH clinics decreased from being 100% of the state network average in 2004 to 92% of the state average in 2008, in a state with costs already well below the national average

Geisinger Health System ProvenHealth Navigator PCMH Model

- Statistically significant 14% reduction in total hospital admissions relative to controls, and a trend towards a 9% reduction in total medical costs at 24 months.
- Estimated \$3.7 million net savings, for a return on investment of greater than 2 to 1.

Genesee Health Plan HealthWorks PCMH Model

- 50% decrease in ER visits and 15% fewer inpatient hospitalizations, with total hospital days per 1,000 enrollees now cited as 26.6 % lower than competitors.

Colorado Medicaid and SCHIP

- Median annual costs \$785 for PCMH children compared with \$1,000 for controls, due to reductions in ER visits and hospitalizations. In an evaluation specifically examining children in Denver with chronic conditions, PCMH children had lower median costs (\$2,275) than those not enrolled in a PCMH practice (\$3,404).

continued

Intermountain Healthcare Medical Group Care Management Plus PCMH Model

- 10% relative reduction in total hospitalizations, with even greater reductions among the subset of patients with complex chronic illnesses. Net reduction in total costs \$640 per patient per year (\$1,650 savings per year among highest risk patients).

Johns Hopkins Guided Care PCMH Model

- 24% reduction in total hospital inpatient days, 15% fewer ER visits, 37% decrease in skilled nursing facility days
- Annual net Medicare savings of \$1364 per patient and \$75,000 per Guided Care nurse deployed in a practice

II. Full Summaries of PCMH Interventions and Outcomes

Group Health Cooperative of Puget Sound

Group Health Cooperative of Puget Sound, a large, consumer owned integrated delivery system in the Northwest, is rolling out a major transformation of its primary care practices. In 2007, Group Health piloted a PCMH redesign at one of its Seattle clinic sites. The redesign included substantial workforce investments to reduce primary care physician panels from an average of 2,327 patients to 1,800, expand in-person visits from 20 to 30 minutes and use more planned telephone and email virtual visits, and allocate daily “desktop medicine” time for staff to perform outreach, coordination, and other activities. The redesign emphasized team-based chronic and preventive care and 24/7 access using modalities including EHR patient portals.

A 12-month controlled evaluation of the pilot clinic redesign, published in a peer-reviewed journal,ⁱⁱⁱ found the following:

- **Better quality:** the pilot clinic had an absolute increase of 4% more of its patients achieving target levels on HEDIS quality measures, significantly different from the control clinic trend; pilot clinic patients also reported significantly greater improvement on measures of patient experiences, such as care coordination and patient activation.
- **Better work environment:** Less staff burnout, with only 10% of pilot clinic staff reporting high emotional exhaustion at 12 months compared to 30% of staff at control clinics, despite being similar at baseline; Group Health has seen a major improvement in recruitment and retention of primary care physicians.
- **Reduction in ER and inpatient hospital costs:** 29% reduction in ER visits and 11% reduction in ambulatory sensitive care admissions.
- **Better value proposition:** an additional investment in primary care of \$16 per patient per year was associated with offsetting cost reductions, with the net result being no overall increase in total costs for pilot clinic patients (the total net cost trend was a savings of \$17 per patient per year, which was not statistically significant). Unpublished data from the 24 month evaluation reportedly show a statistically significant decrease in total costs.

As a result of the success of the pilot clinic redesign, Group Health is currently implementing the PCMH model at all 26 of its primary care clinics serving 380,000 patients.

Community Care of North Carolina

Community Care of North Carolina has more than a decade of experience with innovations in the delivery of primary care to Medicaid and SCHIP beneficiaries. Community Care linked these beneficiaries to a primary care medical home, provided technical assistance to practices to improve chronic care services, directly hired a cadre of nurses to collaborate with practices in case management of high risk patients, and added a \$2.50 (now \$3.00) per member per month care coordination fee for each patient registered with the practice, contingent on practices reporting clinical tracking data. The Community Care PCMH program now involves more than 1,300 community-based practice sites with approximately 4,500 primary care clinicians throughout North Carolina.

An external evaluation^{iv, v} concluded that the Community Care of North Carolina PCMH model resulted in:

- **Better quality:** 93% of asthmatics received appropriate maintenance medications; diabetes quality measured improved by 15%
- **Lower costs:** 40% decrease in hospitalizations for asthma and 16% lower ER visit rate; total annual savings to the Medicaid and SCHIP programs are calculated to be \$135 million for TANF-linked populations and \$400 million for the aged, blind and disabled population.

continued

HealthPartners Medical Group

HealthPartners Medical Group, a 700 physician group that is part of a consumer-governed health organization in Minnesota, implemented a PCMH model in 2004 as part of its “BestCare” model of delivery system redesign. The BestCare model invested in better care coordination centered in the primary care medical home, including proactive chronic disease management through phone, computer, and face-to-face coaching. The program also emphasized more convenient access to primary care through online scheduling, test results, email consults, and post-visit coaching.

A 5-year prospective evaluation of the PCMH approach used in the HealthPartners BestCare model, as reported by the Institute for Healthcare Improvement, found the following results:

- **Better quality:** 129% increase in patients receiving optimal diabetes care, 48% increase in patients receiving optimal heart disease care
- **Better access:** 350% reduction in appointment waiting time
- **Reduction in ER and inpatient hospital costs:** 39% decrease in emergency room visits, 24% decrease in admissions
- Overall costs in the BestCare clinics decreased from being equal to the state network average in 2004 to 92% of the state average in 2008, in a state with costs already well below the national average.

Geisinger Health System ProvenHealth Navigator PCMH Model

The Geisinger Health System, a large integrated delivery system in Pennsylvania, implemented a PCMH redesign in 11 of its primary care practices beginning in 2007. Their ProvenHealth Navigator model focuses on Medicare beneficiaries, emphasizing primary care-based care coordination with team models featuring nurse care coordinators, EHR decision-support, and performance incentives.

Two-year follow-up results from an as-yet unpublished controlled evaluation^{vii} show:

- **Better quality:** Statistically significant improvements in quality of preventive (74.0% improvement), coronary artery disease (22.0%) and diabetes care (34.5%) for PCMH pilot practice sites.
- **Reduction in costs:** Statistically significant 14% reduction in total hospital admissions relative to controls, and a trend towards a 9% reduction in total medical costs at 24 months.

Geisinger estimates a \$3.7 million net savings from the implementation of its PCMH model, for a return on investment of greater than 2 to 1, and is spreading the ProvenHealth Navigator PCMH model throughout the Geisinger Health System.

Genesys HealthWorks

The Genesys HealthWorks based in Flint, Michigan developed a PCMH model for its health plan serving 25,000 uninsured adults. The Genesys PCMH model, called Genesys HealthWorks, invested in a team approach to improve health and reduce costs, including a Health Navigator to work with primary care clinicians to support patients to adopt healthy behaviors, improve chronic and preventive care, and provide links to community resources.

A 4-year longitudinal evaluation of the PCMH approach used in the Genesys HealthWorks model, as reported by the Institute for Healthcare Improvement,^{viii} found the following results:

- **Improved access:** 72% of the uninsured adults in Genesys County now identify a primary care practice as their medical home
- **Better quality:** 137% increase in mammography screening rates; 36% reduction in smoking and improvements in other healthy behaviors
- **Reduction in ER and inpatient costs:** 50% decrease in ER visits and 15% fewer inpatient hospitalizations, with total hospital days per 1,000 enrollees now cited as 26.6 % lower than competitors.

Colorado Medicaid and SCHIP

The Colorado Department of Health Care Policy and Financing has implemented a PCMH program for low income children enrolled in the state's Medicaid and SCHIP programs. To qualify as medical homes, primary care practices must have 24/7 access, open access systems or similar convenient scheduling of appointments, and provide care coordination, which make practices eligible for extra pay for performance payments indexed to EPSDT metrics. As of March 2009, 150,000 children were enrolled in Colorado PCMH practices, involving 97 different community-based practices and 310 physicians.

The Colorado Department of Health Care Policy and Financing has performed an internal evaluation of its PCMH program,^{ix} comparing children in PCMH practices to those care for in usual care practices, and found:

- **Better quality:** 72% of children in the PCMH practices have had well-child visits, compared with 27% of controls.
- **Lower costs:** Median annual costs were \$785 for PCMH children compared with \$1,000 for controls, due to reductions in ER visits and hospitalizations. In an evaluation specifically examining children in Denver with chronic conditions, PCMH children had lower median costs (\$2,275) than those not enrolled in a PCMH practice (\$3,404).

continued

Intermountain Healthcare Medical Group Care Management Plus PCMH Model

Intermountain Healthcare Medical Group, part of an integrated delivery system in Utah, began implementing a PCMH redesign model in 2001. The Care Management Plus PCMH model focuses on primary care-based care coordination of high risk elders, embedding RN care managers in primary care practices and enhancing EHR functionality in support of chronic care and care coordination.

A well-designed controlled 2-year evaluation published in peer-reviewed journals^x documented:

- **Better quality:** absolute reduction of 3.4% in 2-year mortality (13.1% died in PCMH group, 16.6% in controls)
- **Lower costs:** a 10% relative reduction in total hospitalizations, with even greater reductions among the subset of patients with complex chronic illnesses. Net reduction in total costs was \$640 per patient per year (\$1,650 savings per year among highest risk patients).

Based on these evaluation results, the Care Management Plus PCMH model is now being implemented at more than 75 practices in more than six states. (Dorr et al., 2007a; Dorr et al., 2008).

Johns Hopkins Guided Care PCMH Model

The Guided Care PCMH model, developed by an interdisciplinary team at the Johns Hopkins Bloomberg School of Public Health, features care coordination by RN-primary care physician teams working in community-based practices. Guided Care RNs are trained to coordinate care, monitor patients and teach patients and families self-management skills, including early identification of worsening symptoms that can be addressed before an emergency department or hospital admission becomes necessary. The RNs focus on Medicare beneficiaries in the top quartile of health risk.

A preliminary evaluation after eight months of a cluster randomized trial of this model involving 904 patients has been published in a peer-reviewed journal.^{xi} The trends indicate, on average:

- 24% reduction in total hospital inpatient days
- 15% fewer ER visits
- 37% decrease in skilled nursing facility days
- Annual net Medicare savings of \$75,000 per Guided Care nurse deployed in a practice
- The Guided Care patients were more than twice as likely as usual care patients to rate the quality of their care highly.

Erie County PCMH Model

- In the 1990s, Erie County, NY implemented a primary care medical home program for dual eligible Medicaid-Medicare patients with chronic disabilities, including substance abuse. A key part of the intervention was a per-member/per-month care coordination fee to primary care practices to support enhanced team-based chronic care management. An evaluation published in a peer-reviewed journal found that the intervention improved quality of care, decreased duplication of services and tests, lowered hospitalization rates, and improved patient satisfaction while saving \$1 million for every 1000 enrollees.^{xii}

Geriatric Resources for Assessment and Care of Elders

The Geriatric Resources for Assessment and Care of Elders (GRACE) program, situated at an urban system of community clinics affiliated with the Indiana University School of Medicine, enrolled low-income seniors with multiple diagnoses, one-fourth of whom were at high risk for hospitalization. The GRACE PCMH model included a nurse practitioner/social worker care coordination team, working closely with primary care physicians and a geriatrician. At two years, the use of the emergency department was significantly lower in the group receiving the GRACE intervention compared with controls. The subgroup defined at the start of the study as having a high risk of hospitalization was found to have a significantly lower hospitalization rate compared with high-risk usual care patients.^{xiii}

Endnotes

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- ^x Dorr DA, Wilcox AB, Brunner CP, et al. The effect of technology-supported, multidisease care management on the mortality and hospitalization of seniors. *J Am Geriatr Soc.* 2008;56(12):2195-202. Findings updated for presentation at White House roundtable on Advanced Models of Primary Care, August 10, 2009.
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Demonstration/Pilot Program Guidelines

PCPCC Endorsed—March 2009

The following chart outlines the guidelines for PCMH demonstration projects developed by the American Academy of Family Physicians (AAFP), American Academy of Pediatrics (AAP), American College of Physicians (ACP), and American Osteopathic Association (AOA), which the PCPCC endorsed in March 2009. These guidelines are

designed to help ensure that demonstration projects purporting to test the PCMH model are broadly consistent with the Joint Principles.² In addition, the standardization promoted by the acceptance of these guidelines will help facilitate more meaningful interpretation and understanding of the “lessons learned” from the different PCMH demonstration projects.

Collaboration and Leadership

1. The project is open to input from all relevant stakeholders. Examples of relevant stakeholders include professional societies, payers, local large employers/purchasers, health care-oriented community groups including patient advocacy groups, and representatives from local/regional quality improvement programs.
2. The project ensures that the leaders of local/regional primary care professional organizations are adequately briefed about the project.
3. The project identifies an entity that is responsible for convening all participants and coordinating the activities of the project.

Practice Recognition

4. The project uses the National Committee for Quality Assurance (NCQA) Physicians Practice Connections (PPC) PCMH tool, or a similar, consensus-based recognition process that includes validation of PCMH practice attributes defined in the “Joint Principles.”³
5. The project includes participation of a range of practice sizes, and is representative of the area in which the project is taking place.
6. The project clearly outlines the responsibilities of all participating parties, including providers, payers, patients/families and other relevant stakeholders.

²American Academy of Pediatrics, American Academy of Family Physicians, American College of Physicians, American Osteopathic Association. *Joint Principles of the Patient Centered Medical Home*. March 2007. Accessible at <http://www.pcpcc.net/content/joint-principles-patient-centered-medical-home>.

³Ibid.

Practice Support

7. The project provides participating practices with sufficient financial and non-financial support to at least cover the costs of the PCMH recognition approval process; additional physician, clinical staff, and administrative staff work associated with the project; and implementation of the practice infrastructure required to provide services consistent with the PCMH care model.
8. The project encourages the incorporation of and support for Health Information Technology (HIT) solutions to facilitate: Care Management and Care Coordination by the medical team; Patient and Family Access to educational material and electronic communications; and/or Performance Reporting (including the Patient/Family Experience, Quality Outcomes and Improvement, and Healthcare Resource Utilization).
9. The project design maximizes the number of patients in each participating practice covered by the demonstration project. This can be accomplished in multiple ways, including the participation of multiple payers and the use of broad criteria for patient participation (e.g., child, adult, and elderly participants; patients with chronic and non-chronic conditions).

Reimbursement Model

10. The project's payment model is broadly consistent with the following:
 - A prospective, bundled component that covers physician and administrative staff work and practice expenses linked to the delivery of services under the PCMH model not covered by the most current Medicare RBRVS system.
 - A visit-based fee component for services delivered as part of a face-to-face visit and that are already recognized by the most current Medicare RBRVS system.
 - A performance-based component based on the achievement of defined quality and efficiency goals as reflected by evidence-based quality, cost of care and patient experience measures.
 - The payment model should recognize differences in the level of PCMH care provided and patient case mix/complexity.

Assessment and Reporting of Results

11. The project provides evidence supporting that it is of sufficient duration to reasonably expect the impact of the model to be demonstrated.
12. The project contains a commitment to an external evaluation to ensure the integrity and credibility of the project's data and reports.
13. The project contains a commitment to transparency of the data set, including the selection, use and reporting of results from clinical metrics, financial measures and the application of proprietary measures of performance.

continued

(continued)

Assessment and Reporting of Results

14. The project includes, at a minimum, the following data collection categories:
 - Descriptive data of the participating patients and practices.
 - Process and outcome measures of clinical quality with preference for those measures approved by the AQA and the National Quality Forum (NQF).
 - Measures of resources used, which can include cost of care to the payer and patient, and net effect of the care model on the financial performance of the participating practices.
 - Measures of patient/family experience of care with a preference for nationally recognized measures.
 - Measures of the experience and/or satisfaction of participating physicians, practice staff, and payers with the model.
15. The project measures the qualitative and quantitative (i.e., resource utilization) effects of the PCMH delivery and payment model on the broader health care community, e.g., subspecialty and specialty practices, hospital/emergency room care.
16. The project includes a process to broadly and publicly disseminate its results.

NCQA Scoring Criteria

Standard 1: Access and Communication	Pts.
A. Has written standards for patient access and patient communication**	4
B. Uses data to show it meets its standards for patient access and communication**	5
	9

Standard 2: Patient Tracking and Registry Functions	Pts.
A. Uses data system for basic patient information (mostly non-clinical data)	2
B. Has clinical data system with clinical data in searchable data fields	3
C. Uses the clinical data system	3
D. Uses paper or electronic-based charting tools to organize clinical information**	6
E. Uses data to identify important diagnoses and conditions in practice**	4
F. Generates lists of patients and reminds patients and clinicians of services needed (population management)	3
	21

Standard 3: Care Management	Pts.
A. Adopts and implements evidence-based guidelines for three conditions**	3
B. Generates reminders about preventive services for clinicians	4
C. Uses non-physician staff to manage patient care	3
D. Conducts care management, including care plans, assessing progress, addressing barriers	5
E. Coordinates care/follow-up for patients who receive care in inpatient and outpatient facilities	5
	20

Standard 4: Patient Self-Management Support	Pts.
A. Assesses language preference and other communication barriers	2
B. Actively supports patient self-management**	4
	6

Standard 5: Electronic Prescribing	Pts.
A. Uses electronic system to write prescriptions	3
B. Has electronic prescription writer with safety checks	3
C. Has electronic prescription writer with cost checks	2
	8

continued

Standard 6: Test Tracking	Pts.
A. Tracks tests and identifies abnormal results systematically**	7
B. Uses electronic systems to order and retrieve tests and flag duplicate tests	6
	13

Standard 7: Referral Tracking	Pts.
A. Tracks referrals using paper-based or electronic system**	4
	4

Standard 8: Performance Reporting and Improvement	Pts.
A. Has written standards for patient access and patient communication**	3
A. Measures clinical and/or service performance by physician or across the practice**	3
B. Survey of patients' care experience	3
C. Reports performance across the practice or by physician**	3
D. Sets goals and takes action to improve performance	2
E. Produces reports using standardized measures	1
F. Transmits reports with standardized measures electronically to external entities	
	15

Standard 9: Advanced Electronic Communications	Pts.
A. Availability of Interactive Website	1
B. Electronic Patient Identification	2
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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