Supporting the Patient Centered Medical Home in Medicaid and SCHIP: Infrastructure

Wednesday, April 2, 2008
Noon - 1:30 p.m. Eastern

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Supported by The Commonwealth Fund
How do we know a practice is a PC-MH?

NASHP Webcast April 2, 2008

Ann S. O’Malley, MD, MPH
Center for Studying Health System Change
Washington, DC
How do we know a practice is a patient-centered medical home?

- First need to define the PC-MH:
  
  (Joint Principles of the ACP, AAFP, AAP, AOA)

  “Physician directed medical practice that provides patient centered care that is accessible, continuous, comprehensive, coordinated and delivered in the context of family and community.”
Also Known As.....Primary Care

PC-MH Provides:

1. **First contact care**- Point of entry for new problems ("Gateway")

2. **Longitudinality**- ongoing care over time

3. **Comprehensiveness**- provides or arranges for services across all of a patient’s healthcare needs

4. **Coordination**- integration of care across a person’s conditions, providers & settings

How do we know a provider practice is a patient-centered medical home?

To capture whether a practice is a PC-MH, measures should include:

<table>
<thead>
<tr>
<th>Structure (Capacity)</th>
<th>Process (Performance)</th>
</tr>
</thead>
<tbody>
<tr>
<td>First Contact Care</td>
<td>Accessibility</td>
</tr>
<tr>
<td>Longitudinal Care</td>
<td>Eligible Pop.</td>
</tr>
<tr>
<td>Comprehensiveness</td>
<td>Range of Services</td>
</tr>
<tr>
<td>Coordination of Care</td>
<td>Continuity</td>
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<tr>
<td></td>
<td>Utilization</td>
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<tr>
<td></td>
<td>Utilization</td>
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<td></td>
<td>Prob Recog &amp; Util.</td>
</tr>
<tr>
<td></td>
<td>Problem Recog</td>
</tr>
</tbody>
</table>

(Starfield 1992, 1998; Donabedian; Millis 1966, Alpert and Charney 1974; Parker 1974; IOM 1996)
1. First Contact Care

- **Structure (Capacity)**
  - **Accessibility**
    - Geographic access
    - Phone access
    - Appointment making ease
    - Same day appointment capability
    - After hours care availability and 24x7 coverage
    - Communication, language, cultural orientation
  
  PCMH Qualification Tool should demonstrate that these capacities exist

- **Process (Performance)**
  - **Utilization**
    - Ideally measured at population level to capture those without good access—but for PCMH at a minimum, patient input important here
    - At practice level, can measure extent to which first visit for a new problem occurred at the PCMH-assess visit/claims data
2. Longitudinal Care over time

- **Structure (Capacity)**
  - Patient List/Registry
  - **Mutual recognition** of the PCMH by both parties
    - Personal physician (“PC-MH team”), NP, PA, MA etc
    - Patient
      - PCMH Qualification Tool should demonstrate these capacities

- **Process (Performance)**
  - **Extent to which patient’s care occurs at the PCMH** for all problems except for those for which a referral is indicated
  - **Personal relationship over time**
    - Examples of Measures:
      - % of patient visits that occurred at the PCMH
      - % of patient visits that were with the same practitioner

3. Comprehensiveness

- **Structure (Capacity)**
  - **Range of Services Available at PCMH**
    - Provides services to meet all common health needs
    - Clinically indicated care based on age, needs and complexities
    - Preventive, Acute, Basic Procedures, Ongoing care for Chronic Conditions
  - **Ability to arrange for services that are too uncommon for PCMH to provide**

- **Process (Performance)**
  - **Recognition of Patient Needs**
  - **Utilization**
    - Chart audits/records provided by facility as to delivery of services
    - Information on types of problems and diagnoses seen
    - Extent to which care occurs in the PCMH vs gets referred out
4. Coordination of Care

- **Structure (Capacity)**
  - **Continuity**
    - Either visit continuity with a qualified practitioner, or
    - Medical record continuity of information from visit to visit
      Ideally, both are present

- **Process (Performance)**
  - **Problem Recognition**
    Information on the status of problems is noted from previous visits, including information on care received outside of the PCMH, in a way that gets recognized by the patient’s personal physician/PC-MH team at the present visit.

  - **Referrals are coordinated** and tracked by PC-MH
What’s important in measuring PCMH?

- **Validity** of measures-capture the concepts properly
- **Evidence** that concept measured is associated with improved processes and outcomes for patients
- **Feasible**- not overly burdensome for practices or for Medicaid
- **Triangulate**- Ideally, should incorporate provider and patient input and clinical data to some extent
- At this point, most efforts are trying to start with measuring PCMH at the practice/facility level with some effort to incorporate whether the PCMH also surveys patients on their access
- **Measure achievement** rather than mere potential
Existing MH Measurement Tools

No single tool has been identified as ideal for MH Demos

Tools that have a practice or facility component:

- **Research Tools for PC Assessment & MH QI**
  - PCAT-(Primary Care Assessment Tool) Starfield & Cassidy
  - MHI (Medical Home Index)-Cooley & McAllister
  - ACIC (Assessment of Chronic Illness Care) Wagner et al
  - ACOVE-3 (Assessing Care of Vulnerable Elders) Wenger et al

- **Tools that QI or MH demonstrations in private and public sectors are considering or have used in the past**
  - PPC-PCMH (NCQA)-A revised version
  - Bridges to Excellence (BTE) Office Assessment Tools
  - State QI Efforts (Mass, Maine, Penn, RI)
For the purposes of PC-MH Qualification—Cautions

- Need to adapt/modify/shorten existing tools with the program objectives in mind

- Risk of overemphasis on IT structures and practice redesign, while underemphasizing key PC elements

- Don’t let the limitations of existing tools limit how we “define” and measure medical home functions and key elements

- Risk of “over-measuring” primary care and “under-measuring specialty care” going forward
Supplementary Slide: Procedures the PCMH can perform

- Immunizations
- Family Planning
- Counseling for behavior and simple mental health problems
- Common Procedures
  - Pulmonary Function Tests
  - EKG
  - Pap smears
  - IUD placement
  - Foreign body removal (ear, nose)
  - Simple laceration repairs
  - Cyst removal as appropriate
  - Joint aspirations and injections etc.
Questions?
Strategies Medicaid and SCHIP programs can use to support medical home performance

Presented by:

Neva Kaye
Senior Program Director
National Academy for State Health Policy

April 2, 2008

The Commonwealth Fund is supporting the Taskforce for Implementation of the Patient-centered Medical Home Model in State Medicaid And SCHIP Programs
Strategies to support performance (Other than Reimbursement)

• Provide information to primary care practices
  – About their individual patients
  – About their performance
  – About best practices
• Assist practices in coordinating care
  – Provide practices with resources to coordinate care
  – Provide practice-centered care coordination through separate system/contract
• Health Information Technology (HIT)
Putting the Pieces Together
How three states are supporting practices

• Illinois
  – Support in caring for beneficiaries with a broad range of needs
  – Primary Care Case Management (PCCM) delivery system
    Dr. Steve Saunders, Medical Advisor to the Illinois Medicaid Director

• Pennsylvania
  – Support in caring for SCHIP beneficiaries with special health care needs
  – Comprehensive MCO delivery system
    Lowware Holliman, Operations Manager, Division of Quality Assurance, Pennsylvania CHIP and adultBasic Programs
    Dr. Carey Vinson, Vice President, Quality and Medical Performance Management, Highmark, Inc.

• Arizona
  – Using HIT to support and measure performance by plans and practices
    Anthony Rodgers, Director, Arizona Health Care Cost Containment System
ILLINOIS PRIMARY CARE
CASE MANAGEMENT (PCCM)
MEDICAL HOME INITIATIVE

NASHP/PCPCC WEBCAST
April 2, 2008

Stephen E. Saunders, M.D., MPH
Medicaid Medical Advisor
Illinois Background

• 2.3 Million beneficiaries in HFS programs

• Primarily fee-for-service

• Voluntary HMO managed care in Cook and seven other rural counties (170,000 members)
System Change

- Focus on access and quality, while managing costs
- Implement PCCM program to assure medical home
- Implement disease management (DM) program with risk-based contract
- Enhance quality/performance in MCO contract
- Monitor some HEDIS measures in PCCM & MCO
What is Primary Care Case Management (PCCM)?

- Combines managed care & fee-for-service
- Provide each participant w/a medical home
- Primary Care Providers (PCPs) responsible for coordinating provision of health services to consumer
- Increase utilization of primary care and preventive services
- Better continuity, coordination and quality
Medical Home

• Primary Care Case Management
  – Administrator responsible for provider recruitment, client enrollment, quality and EPSDT compliance.
  – Designed to ensure Medical Home
  – 1.7 million beneficiaries eligible

• Disease Management population is a subset
  – 220 beneficiaries eligible
  – Targets disabled adults and children with asthma

• Member encouraged to choose PCP but if no choice then auto assigned

• Members in Voluntary MCO Counties choose PCCM or MCO
Program Status

• PCCM development began in Fall 2006, started enrollment in 2/07
• Currently, statewide enrollment complete
  – 1.6 million members enrolled
  – 5,300 medical homes (physicians and clinics) with over 5 million member capacity
• Improving access to preventive & primary care, and chronic disease management
• DM program started 7/06
Care Management Fee

- PCPs paid PMPM for care management:
  - $2.00 per child
  - $3.00 per parent
  - $4.00 per disabled or elderly enrollee
- Monthly care management fee paid even if the enrollee gets no services that month.
- PCPs continue to receive their regular reimbursement for services
PCP REQUIREMENTS

• Maintain hospital admitting and/or delivery privileges or have arrangements for admission
• Make medically necessary referrals to HFS enrolled providers, including specialists, as needed
• Provide direct access to enrollees through an answering service/paging mechanism or other approved arrangement for coverage 24 hours a day, 7 days a week. Automatic referral to an emergency room does not qualify
• Maintain office hours of at least 24 hours/week (solo practices) or 32 hours/week (group practices)
• Follow recognized preventive care guidelines
• Manage chronic disease
PCP SUPPORT

- PCP access to secure web portal which contains PCP support materials
- Patient roster
  - Mailed monthly but also available electronically
  - Provides information on needed preventive services
    - Well child visits
    - Pap smears
    - Mammograms
  - Electronic version sortable
PCP SUPPORT (continued)

• Provider profiles
  – 20 HEDIS and HEDIS-like metrics
  – System and provider specific performance
  – Listing of members with chronic diseases and their level of metric compliance.

• Historical claims:
  – 2 years Medicaid claims: Pharmacy, Office visits, Hospitalization, Diagnosis, Procedures
  – 7 years of immunization data
PCP SUPPORT (continued)

• Pay for Performance
  – Bonus payment for meeting National 50th HEDIS percentile.
  – Measures
    • Immunizations
    • Developmental Screening
    • Asthma Management
    • Diabetes Management (HbA1C)
    • Mammograms
    • EPSDT (Well Child)
PCP SUPPORT (continued)

• Provider Services Representatives
  – 11 Provider Services Reps in field
  – Provider Services Help desk
  – Outreach and Education to support Providers and their staff
    • Site Visits
    • Training Sessions: Billing, EPSDT Support, Quality Assurance
    • Monthly Webinars
    • Specialty Resource Database

• Provider Newsletter and web site
PCP Assistance with EPSDT

- Outreach to families
  - encourage preventive visits
  - target non-compliant families
- Follow up to families who have not received appropriate primary care
- Assist families in setting up appointments
- Assist PCP’s with recall system
- Provide PCP training on EPSDT & billing
- Assist PCP with referrals
PCP Support for DM Members

• Support provider’s plan by facilitating patient compliance

• Nurses provide
  – Education to patients with chronic conditions
    • to help them better understand their disease
    • follow care plan and medication requirements
  – Intensive care management to most complex patients

• Emphasize importance of making scheduled visits to reduce no shows
PCP Support for DM Members (2)

- Support PCP in post ER & hospitalization follow-up
- Notify PCP of any urgent medical problem or medication management/compliance issues
- Practice-level patient rosters, and patient-level care plans
- Claims-based practice profiles provide
  - chronic disease specific utilization data
  - assist physicians in tracking adherence to treatment guidelines
- PCPs receive support in identifying patients with unusual drug utilization patterns
Provider Continuing Education

- Education program provided by AAP and AFP under subcontract

- Medical Education on evidence-based evaluation and management of common chronic conditions.
  - Chronic Care Model
  - Asthma
  - Depression
  - Diabetes
  - COPD
  - Substance Abuse

- Topics also include preventive health
  - Immunizations
  - Developmental Assessment
  - Medical Home

- In-Office training for physician and staff
PCCM Quality Measures

• Childhood immunizations
• Lead testing
• Developmental screening
• Appropriate medications asthma, diabetes care (HbAic)
• Well baby/well child visits
• Cervical cancer screening
PCCM Quality Measures - Continued

- Adolescent well care
- Prenatal care frequency/timeliness
- Post partum care
- Depression treatment
- Adult access to preventive care
- ER visits/1000
- Ambulatory care sensitive hospital visits
CHILDREN’S HEALTH INSURANCE PROGRAM

Children with Special Health Care Needs

NASHP/PCPCC Webcast
April 2, 2008
Lowware Holliman, Chief
Division of Quality Assurance
Program History

- The CHIP Program was enacted in December of 1992.
- One of the longest standing children’s health insurance program in the country.
- Medical services are provided through eight (8) managed care organizations covering 67 counties.
- CHIP currently serves approximately 170,000 children ages 0-18.
Problem

- CHIP provides benefits that cover children with special health care needs generally.

- CHIP referrals children with severe health care needs to Pennsylvania’s Medicaid program to obtain a more enhanced benefit package which includes intense case management.

- Over time we have discovered that a significant number of children referred to Medicaid do not meet its threshold of medical necessity.
Problem (cont’d)

- Due to the complexity of the child’s condition and/or family circumstances, children with special needs require more tailored personal assistance, but their families find it difficult to navigate the system to obtain community or school based care coordination.

- Physicians typically are unaware or unable to make referrals to appropriate community based resources.
Solutions

- In the CHIP RFP covering contract years 2005-2008, provisions were included to encourage contractors to establish medical homes, particularly in the case of PPO delivery systems.

- Contractors were encouraged to design and test innovative programs to meet the needs of their particular CHIP populations.
In January of 2005, Highmark’s Caring Foundation presented the CHIP office with its Care Coordination Program for Children with Special Health Care Needs and Their Families.

The CHIP office collaborated and approved the pilot project which was initiated in March of 2005.

The Caring Foundation, for the past three years, has provided the CHIP program with test results that measure the efficiency of its program.

Results have been positive and consistently encouraging over that time period.
Next Steps

- In the next CHIP RFP scheduled for implementation in December 2008, the CHIP program is considering replicating the Caring Foundation’s program to the degree that it comports with the requirements of the current administration’s plans for expanded health care in Pennsylvania.
NASHP/PCPCC Webcast
April 2, 2008
Carey Vinson, MD, MPM
VP, Quality & Medical Performance Management
Children with Special Health Care Needs

● Children who have a special health care need
  – Nationally 13.9%  PA 15.3%  Highmark CHIP 17%

● Family members cut back or stop working due to child’s condition
  – Nationally 23.8%  PA 24.4%

● Children with 11 or more days of school absences due to illness
  – Nationally 14.3%  PA 15.2%

Highmark Inc. & Highmark Caring Foundation

Highmark, the largest health insurance company in PA, is one of 9 contractors for the Pennsylvania Insurance Department’s CHIP product. Over 55,000 children are currently enrolled in HMO/PPO products through Highmark.

The Highmark Caring Foundation is a non-profit affiliate of Highmark that exists to make a difference for those in need by creating innovative models that change systems of care.

Our Caring Program: Care Coordination for Children with Special Health Care Needs and Their Families provides family-centered, community-based care coordination that is continuous, comprehensive, and coordinated to children enrolled in CHIP through Highmark.
State Partnership

- 2004 – PA Insurance Department granted the Highmark Caring Foundation permission to administer a model care coordination program for children enrolled in the SCHIP through Highmark.

Since 2004 – The Caring Program’s staff has participated in the Pennsylvania Chapter of the AAP EPIC-IC Program. (Educating Practices in Community Integrated Care Medical Home Program)
Programmatic Support Levels

Level 1:
- 49 counties of PA
- All CHIP members enrolled through Highmark
- Telephonic, email or written support
- Education and referral information provided
- Over 8,000 enrollees to date

Level 2:
- 49 counties of PA
- All CHIP members enrolled through Highmark with a primary physical health care need
- Community-based nurses meet face to face with families and providers
- Over 425 enrollees to date
Level 2 Enrollment

- Support families and physician
  - Identify and communicate with the child’s PCP (Medical Home)
  - Coordinate communication among physicians, families and schools
- Annual home visits with the family and quarterly telephone calls
- Create individualized care plans for every child
- Advocate for children at school meetings
- Facilitate the medical/educational training for schools
- Provide referrals to community support and services
- Assist in transition planning
Support for CSHCN

The Caring Program identified that the needs of the children with special health care needs were more global than the child’s primary physical condition.

Key areas of support focused on:

- **Families**
  - Basic physiologic needs (housing, food, heat, emotional support, etc.)
  - Education related to the diagnosis and community resources
  - Create individualized care plans

- **Physicians and Their Practices**
  - Provide introductory letters to the PCP’s of children enrolled in Caring Program
  - Children’s care plans are shared with physician practices with parental approval
  - Provide appropriate (non-medical) referral information (Resource and Information Guide)
  - Provide assistance in coordinating care and communication among multiple practitioners and facilities
  - Provide family-centered education to the family to support adherence to the physician medical care plan

- **Schools**
  - Helping families communicate and educate their child’s school to ensure their child is in a inclusive environment and has appropriate physical and educational accommodations
Population Identification

- Claims data
- CAHMI* +
  - (Children and Adolescent Health Measurement Initiative)
- State provided disability data
- Health Management Services
  - (Case Management)
- Community Referrals

*Data Resource Center for Child and Adolescent Health  www.childhealthdata.org
CAHMI – Child and Adolescent Health Measurement Initiative, 2007
External Evaluation

Conducted by: The Institute for Evaluation Science in Community Health, Department of Behavioral and Community Health Sciences, Graduate School of Public Health, University of Pittsburgh - 2007

- **Psychosocial Analysis**
  - To examine the Caring Program’s impact on the physical, social and educational needs of the child and parent (via parent/caregiver survey)

- **Cost Analysis**
  - To document the health care delivery utilization and costs related to the enrolled child’s primary diagnosis
Psychosocial Outcomes

Hypothesis

- Decreased school absences
- Increased school performance
- Increase social and recreation activities
- Decreased anxiety for parents
- Decrease in work days missed
- Decrease in out-of-pocket health care expenditures

Outcome

- Decreased school absences ($p = .003$)
- Decrease in problems with grades ($p < .001$)
- Increase in recreation activities ($p < .001$)
- Decreased anxiety for parents ($p = .000$)
- Trend toward fewer work days missed ($p = .094$)
- Less post-intervention out of pocket expenses ($p = .039$)

P values in bold are statistically significant.
Psychosocial Conclusion

“The quality of life for children with special health care needs and their families enrolled in Level 2 of the Program has been meaningfully improved.”

Source: The Institute for Evaluation Science in Community Health, Department of Behavioral and Community Health Sciences, Graduate School of Public Health, University of Pittsburgh - 2007
Cost Analysis
(Related to Primary Diagnosis)

**Hypothesis**
- Decrease in Emergency Department (ED) visits
- Decrease in unplanned inpatient admissions
- Decrease health care costs (Inpatient, ED, DME, Specialist, and Rx)

**Outcome**
- Decreased Emergency Department visits ($p = .009$)
- Decrease in unplanned inpatient admissions ($p = .045$)
- Decrease in Inpatient, ED, DME, and Specialist
- Increase in Rx

*P values in bold are statistically significant.*
# PMPY Costs

<table>
<thead>
<tr>
<th>Service</th>
<th>Pre Intervention</th>
<th>Post Intervention</th>
<th>First 12 Months</th>
<th>Second 12 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>ED</td>
<td>$140.00</td>
<td>$92.00</td>
<td>$55.00</td>
<td>$55.00</td>
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<tr>
<td>Inpatient</td>
<td>$1,296.00</td>
<td>$555.00</td>
<td>$307.00</td>
<td>$331.00</td>
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<tr>
<td>Specialist</td>
<td>$671.00</td>
<td>$516.00</td>
<td>$255.00</td>
<td>$306.00</td>
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<tr>
<td>DME</td>
<td>$173.00</td>
<td>$154.00</td>
<td>$77.00</td>
<td>$253.00</td>
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<tr>
<td>Rx</td>
<td>$1,518.00</td>
<td>$2,147.00</td>
<td>$674.00</td>
<td>$915.00</td>
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<tr>
<td>Total Cost</td>
<td>$3,798.00</td>
<td>$3,464.00</td>
<td>$1,368.00</td>
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<tr>
<td>Total cost without Rx</td>
<td>$2,280.00</td>
<td>$1,317.00</td>
<td>$694.00</td>
<td>$945.00</td>
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</tbody>
</table>
# Paired Sample T-Tests: Pre Versus Post Intervention

<table>
<thead>
<tr>
<th></th>
<th>Pre-Intervention</th>
<th>Post-Intervention</th>
<th>t statistic</th>
<th>p</th>
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</thead>
<tbody>
<tr>
<td><strong>Number of Hospitalizations</strong></td>
<td>0.29</td>
<td>0.07</td>
<td>2.799</td>
<td><strong>0.006</strong></td>
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<td><strong>Number of Inpatient Days</strong></td>
<td>1.37</td>
<td>0.39</td>
<td>2.035</td>
<td><strong>0.045</strong></td>
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<td><strong>Costs of Inpatient Care</strong></td>
<td>1296.02</td>
<td>555.16</td>
<td>1.27</td>
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<td><strong>Number of ER Visits</strong></td>
<td>0.62</td>
<td>0.31</td>
<td>2.651</td>
<td><strong>0.009</strong></td>
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<td><strong>Costs of ER Visits</strong></td>
<td>139.94</td>
<td>92.04</td>
<td>1.439</td>
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<tr>
<td><strong>Number of DME by DOS</strong></td>
<td>0.39</td>
<td>0.56</td>
<td>-1.092</td>
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<td><strong>Costs of DME</strong></td>
<td>173.19</td>
<td>153.64</td>
<td>0.197</td>
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<td><strong>Number of Specialists Visits</strong></td>
<td>5.8</td>
<td>4.43</td>
<td>1.755</td>
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<td><strong>Costs of Specialist Visits</strong></td>
<td>670.65</td>
<td>515.6</td>
<td>1.626</td>
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<td><strong>Costs of Rx Program</strong></td>
<td>1518.13</td>
<td>2147.24</td>
<td>-0.896</td>
<td>0.372</td>
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<tr>
<td><strong>Total Costs</strong></td>
<td>3797.93</td>
<td>3463.68</td>
<td>0.378</td>
<td>0.707</td>
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<tr>
<td><strong>Total Costs without Rx</strong></td>
<td>2279.81</td>
<td>1316.44</td>
<td>1.595</td>
<td>0.114</td>
</tr>
</tbody>
</table>

*P values in bold are statistically significant.

Source: The Institute for Evaluation Science in Community Health, Department of Behavioral and Community Health Sciences, Graduate School of Public Health, University of Pittsburgh - 2007
Cost Analysis Conclusion

- The cost savings point estimate is $334.00 PMPY; however, there is variation around this estimate.

- The overall cost of the control group increased while the intervention group costs decreased.

Source: The Institute for Evaluation Science in Community Health, Department of Behavioral and Community Health Sciences, Graduate School of Public Health, University of Pittsburgh - 2007
Questions?
Medicaid Health System Transformation

*Using Health Information Technology to Support Medical Homes*

Anthony Rodgers, Director
Arizona Health Care Cost Containment System
Discussion Topics

- Goals of Medicaid Transformation
- System Transformation Enablers
- Leveraging Medicaid Transformation Grants to Support Medical Homes in Medicaid/SCHIP
Vision of a Transformed Medicaid Healthcare System

A healthcare system that supports:

- Integrated healthcare delivery,
- Cost and quality transparency,
- Supports productive interchange between provider and patient,
- Informed activated consumers and patients,
- Healthcare provider’s able to provide cost effective care management and use clinical decision support tools to reduce cost and quality variances.
Medicaid Health System Transformation

Improved Systems of Care

Integrated Health

- Virtual Integrated networks
- Effective Medical Homes for Medicaid Enrollees
- Effective Clinical Collaborations
Transforming Medicaid Care Management

Care Management Processes

- Health Assessments
- Behavioral Modification
- Health Information And Prevention
- Public Health

Population Segment

- High Disease Burden
- Single High Impact Disease
- Patients
- Patients and Beneficiaries
Essential Elements for Transforming Patient Care Management

- Electronic Health Record
- Informed, Activated Patient
- Productive Interactions
- Prepared Clinical Team
- Clinical and Value Decision Support Tools
Leveraging Technology

The opportunity for health system transformation has never been greater driven by the widespread deployment and exchange of electronic health records, interoperable health information systems and the application of new telecommunication and biometric technologies.
System Transformation Enabler

Electronic Health Records and Information Technology
- Alert and reminders
- Guidelines
- Clinical knowledge
- Templates

Population Management
- Identify population of individuals
- Performance feedback
- Planning services for subpopulations

Self Management
- Personalized care plan
- Personal health record
- Online goal setting tools

Delivery System Redesign
- Care coordination
- Set goals for optimal health
- Primary care team

Decision Support
- Personalized care plan
- Personal health record
- Online goal setting tools
E-Health Infrastructure of Medicaid System Transformation

Transforming IT Infrastructure

- Health Information Exchange Infrastructure
- Electronic Health Record Infrastructure
- Web based E-Learning Programming Infrastructure
- Knowledge Building and Transfer Infrastructure

Medicaid System Transformation Drivers

Health Care System
HIT Infrastructure Requirements
Medicaid Medical Home

- Provider Access Medicaid Health Record Information
- Patient Tracking and Medicaid Continuity of Care Record
- Care Management Capability
- Patient Care Self-Management Support
- Electronic Prescribing
- Order Entry and Results Reporting Capabilities
- Referral request and results reporting
- Performance Reporting and Quality Improvement
- Supporting Practice Clinical Decision Support and Effective Patient Decision Support tools and Communication with Medicaid Beneficiaries
## Supporting Medical Homes For Medicaid/SHCIP Beneficiaries

<table>
<thead>
<tr>
<th>Areas of Support for Medical Home in Medicaid</th>
<th>Medicaid Transformation Project Area</th>
<th>State's with Projects</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improving Provider Access to Medicaid Health Information</td>
<td>Electronic Health Information Exchange</td>
<td>Washington DC, Hawaii, Connecticut, Arizona, Alabama, Kentucky, Mississippi, New Jersey, New Mexico, Texas, Wisconsin, Indiana, Oregon, Rhode Island</td>
</tr>
<tr>
<td>Patient Tracking and Medicaid Continuity of Care Record</td>
<td>Medicaid/SCHIP EHR</td>
<td>Alabama, Arizona, Washington DC, Minnesota, Missouri</td>
</tr>
<tr>
<td>Care Management</td>
<td>Medicaid/SCHIP EHR</td>
<td>Minnesota, Arizona, Montana, Kansas</td>
</tr>
<tr>
<td>Patient Self-Management Support</td>
<td>Decision Support</td>
<td>West Virginia, Arizona</td>
</tr>
<tr>
<td>Electronic Prescribing</td>
<td>E-prescribing initiatives</td>
<td>New Mexico, Connecticut, Arizona, Florida, Tennessee, Delaware</td>
</tr>
<tr>
<td>Lab Results Reporting</td>
<td>Medicaid/SCHIP EHR</td>
<td>Arizona, Oregon</td>
</tr>
<tr>
<td>Referral Requests and Results Reporting</td>
<td>Medicaid/SCHIP EHR</td>
<td>Arizona, Alabama</td>
</tr>
<tr>
<td>Performance Reporting and Quality Improvement</td>
<td>Quality Improvement Management and Value Driven purchasing.</td>
<td>Minnesota, Illinois, Georgia, Ohio, Wisconsin, Nevada, Pennsylvania</td>
</tr>
</tbody>
</table>
Medicaid Leadership and Know-How in HIT Deployment

Critical Elements for Medicaid Transformation

- There must be a strong Federal and State partnership and financial support
- Agency leadership and participation is critical
- Assuring effective health information system planning and development know-how
- Development of new skills and organizational competencies within State Medicaid Program and Public Health,
- Changing reimbursement strategies and health information exchange policies to maximize participation
- State Level Public/Private partnerships to support HIT infrastructure for Medical Homes
Multi State Collaboration
On Medicaid Transformation
Organization Chart

Multi State Collaboration Steering Committee

Technical Support Consultant

Administrator
Multi State Collaboration

Working Group on HIE
Working Group On EHR
Working Group On Data Structure
Working Group on Legal/Patient Consent
Working Group on Provider Adoption And Deployment
Working Group on Clinical Decision Support

Workgroups
The purpose of Multi State Collaboration workgroups is to organize group learning and project team development opportunities, peer to peer technical assistance, propose common Standards, solutions, strategies, and/or development approaches to the steering committee.

Technical Support Consultants
Technical support consultants will provide technical consultation and assistance to Workgroups including discussion forums, workshops, learning labs and demonstrations, expert consultation, and educational and reference materials.

Administrator, Multi State Collaboration
The Multi State Collaboration Administrator will provide steering committee and Workgroups meetings and administrative support, maintain the document library, web site, organize conferences, manage the collaboration budget, develop funding sources and prepare reports as requested by the steering committee.
Questions?
For more information

- **The Patient Centered Primary Care Collaborative**
  - www.pcpcc.net
  - Edwina Rogers at erogers@eric.org
  - (202)789-1400

- **Center for Studying Health System Change**
  - Ann O’Malley at aomalley@hschange.org
  - www.hschange.org

- **Illinois Department of Healthcare and Family Services**
  - www.ohic.ri.gov or
  - Steve Saunders at Steve.Saunders@illinois.gov

- **Pennsylvania CHIP and adultBasic Programs**
  - Lowware Holliman at
  - lholliman@state.pa.us
  - 717-783-1437

- **Highmark**
  - Carey Vinson, MD, MPM
  - (412) 544-6792
  - carey.vinson@highmark.com or
caringprogram.com

- **Arizona Health Care Cost Containment System**
  - Anthony Rodgers at
  - www.ahcccs.state.az.us
  - Tony.rodgers@azahcccs.gov

- **The National Academy for State Health Policy**
  - www.nashp.org or
  - Neva Kaye at nkaye@nashp.org
  - 207-874-6524

- **The Commonwealth Fund**
  - www.commonwealthfund.org or
  - Melinda Abrams at MKA@CMWF.ORG
Upcoming Event

State Medical Home Summit
  - Bringing together state officials and national experts
  - July 2008 in Washington DC
  - Limited scholarships will be available for state officials

Future webcasts

More details to come from NASHP!

Supported by The Commonwealth Fund