colorado health INSTITUTE

Medical Homes: A New Way To Deliver Health Care

WHAT IS IT?

An innovative health care delivery model being tested in many settings – including Colorado. Designed to counter the medical system fragmentation that can lead to poor care and high costs, the model relies on a health care team quarterbacked by the patient's primary care provider.

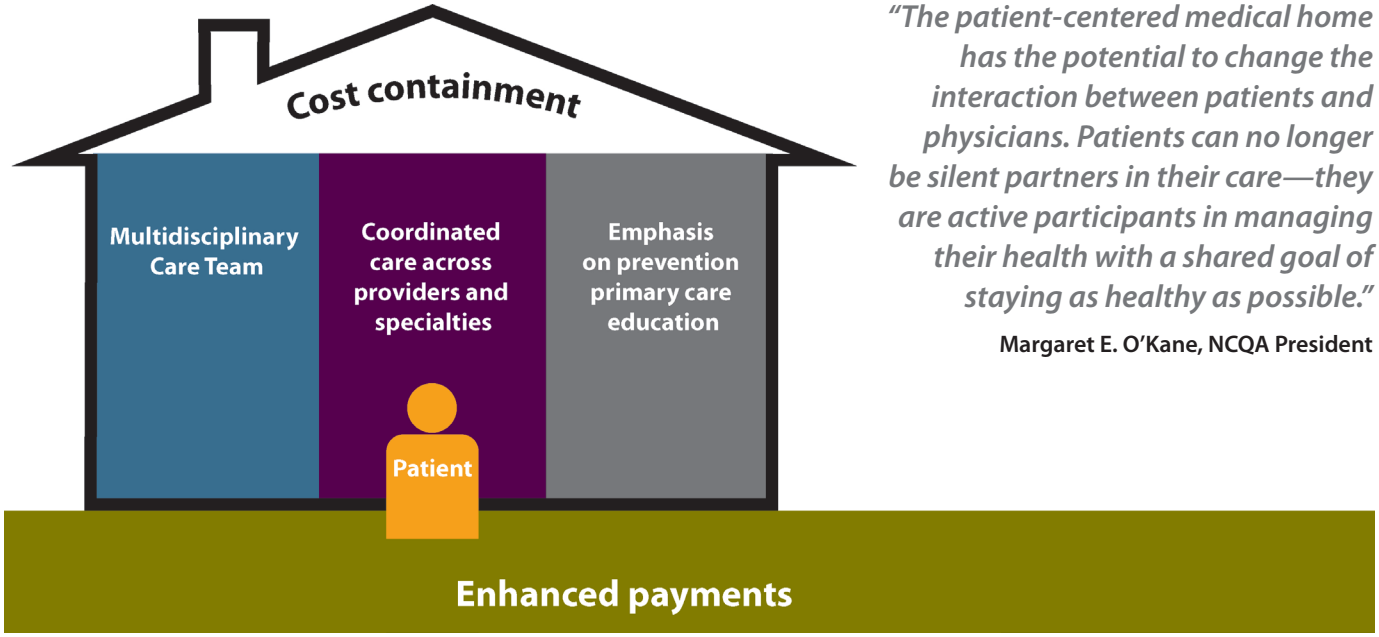
HOW DOES IT WORK?

A patient's medical "home" is really an office or a health clinic where his or her primary care provider works. That provider quarterbacks a team that looks after all aspects of a patient's care, including visits to a specialist or a therapist or even the hospital. The team spends much more time trying to keep the patient from getting sick in the first place, offering education on exercise and healthy eating and making sure preventive care is completed.

WHAT ABOUT COMMUNICATION?

Communication takes center stage. The primary care provider coordinates all discussions. The latest information technology is used to order prescriptions, track test results, monitor a patient's health and generally keep all team members in the loop.

What a medical home looks like



"The patient-centered medical home has the potential to change the interaction between patients and physicians. Patients can no longer be silent partners in their care—they are active participants in managing their health with a shared goal of staying as healthy as possible."

Margaret E. O'Kane, NCQA President

DO MEDICAL HOMES REALLY SAVE MONEY AND IMPROVE HEALTH OUTCOMES?

Evidence-based studies of the medical home model are in their early stages, and vary based on make-up of the patient population, scale of the project and type of medical setting. Still, early findings suggest there has been some improvement in the quality of care and patient experience along with cost reductions from fewer emergency room visits and hospitalizations.

For example, Group Health Cooperative of Puget Sound in Washington saw a 29 percent reduction in emergency room visits and an 11 percent reduction in ambulatory sensitive care admissions. Patients also reported enhanced quality of care, and had more preventive care visits and better emergency care follow-up. Pennsylvania's Geisinger Health System integrated care model estimates a $3.7 million net savings for a return on investment of greater than 2 to 1.

WHAT IS HAPPENING IN COLORADO?

Senate Bill 07-130 set a goal to increase the number of children in the Medicaid and CHP+ public insurance programs who are enrolled in a medical home. This effort, which began in 2007 and is known as the Colorado Medical Home Initiative for Children, now has about 276,000 Medicaid and CHP+ children in medical homes.

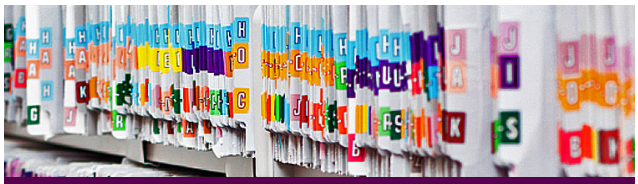
Participating providers receive enhanced fee-for-service payments for serving as the medical home and meeting quality goals. Enhanced payments reward "well care" and proactive primary care evaluations and management services.

Sixteen practices in Colorado are a part of the Multi-Payer, Multi-State Patient Centered Medical Home Pilot, which uses per-member-per-month (PMPM) and pay-for-performance payments from participating health plans – including Anthem-Wellpoint, United Healthcare, Humana, Aetna, CIGNA, Colorado Medicaid and CoverColorado.

276,000

Approximate number of Medicaid and CHP+ children in medical homes as a result of the Colorado Medical Home Initiative for Children

The initiative is being evaluated by a Harvard research team, with results expected later in 2012.



MEDICAL HOME PRINCIPLES

Developed by the National Committee for Quality Assurance (NCQA and several other organizations.

- **Personal physician.** Each patient has an ongoing relationship with a personal physician who is 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 ongoing patient care.
- **Whole-person orientation.** The personal physician is responsible for providing all of the patient's health care needs or for arranging care with other qualified professionals.
- **Care is coordinated** and integrated across all elements of the complex health care system and the patient's community.
- **Quality and safety** are hallmarks of the medical home.
- **Enhanced access** to care is available through open scheduling, expanded hours and other innovative 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.

Anthem has announced that it will pay primary care doctors a bonus for meeting goals for patient care and cost savings, saying that some sites in the Colorado pilot had reduced hospital admissions by 18 percent and emergency room use by 15 percent.

The Safety Net Medical Home Initiative demonstration is helping 14 safety net clinics (community health centers, rural health clinics and community-funded safety net clinics) to become medical homes.

Many more medical home initiatives, including efforts by private practices and clinics across the state, are underway in Colorado.