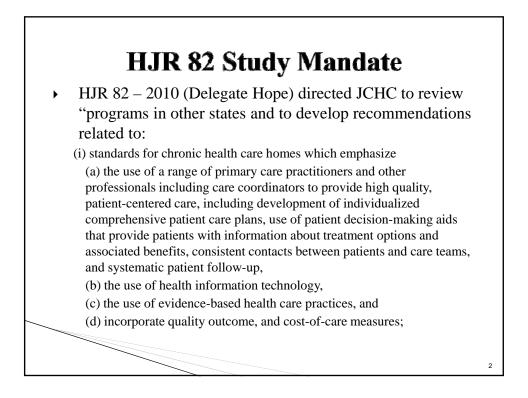
Healthy Living/Health Services Subcommittee

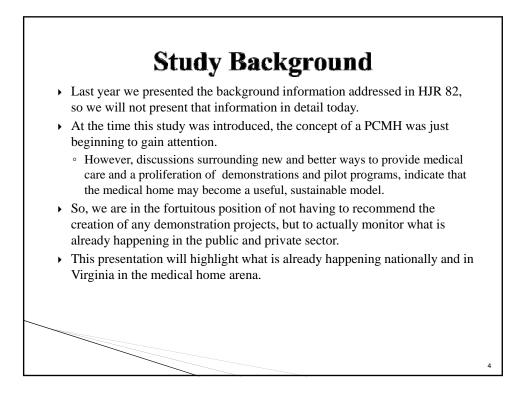
Chronic Health Care Homes (HJR 82-2010)

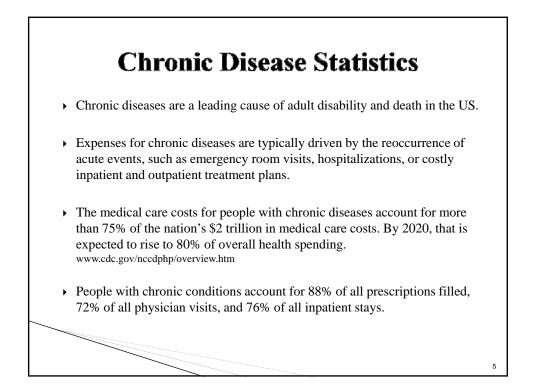
September 19, 2011

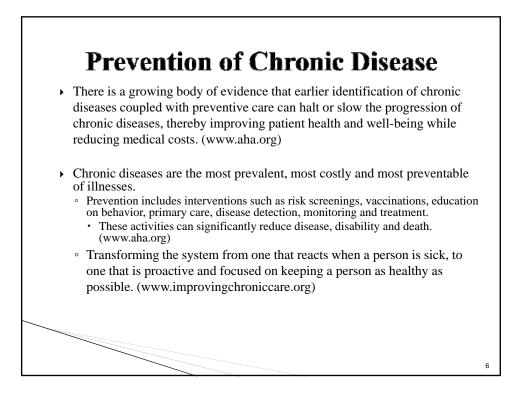
Jaime H. Hoyle Senior Staff Attorney/Health Policy Analyst

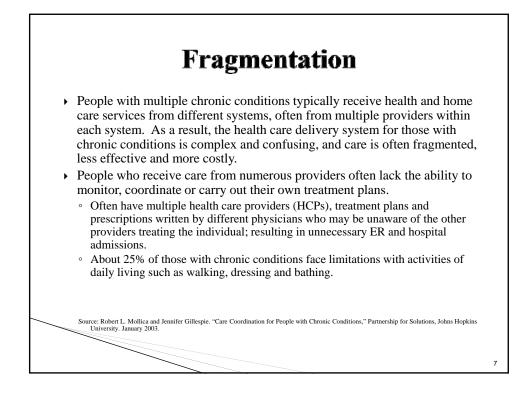


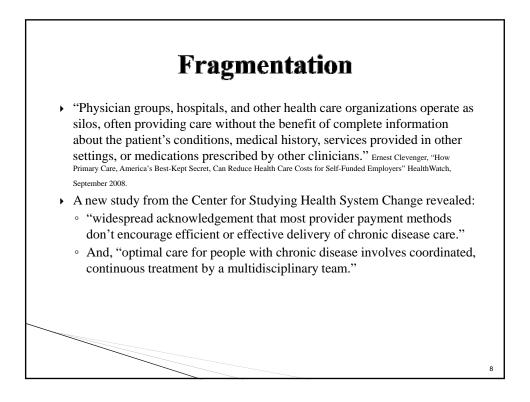
HJR 82 Study Mandate (Cont.) (ii) standards for certification of health care facilities as chronic health care homes including ongoing reporting requirements for chronic health care homes; (iii) development of a chronic health care home collaborative to provide opportunities for chronic health care homes and state agencies to exchange information related to quality improvement and best practices; (iv) enrollment of state medical assistance recipients with chronic health ÷ problems in chronic health care home programs; and (v) costs associated with implementing a successful demonstration program to ٠ test whether chronic health care homes can improve health care quality and patient outcomes, and reduce costs associated with chronic health problems. The Joint Commission on Health Care shall complete its meetings for the first year by November 30, 2010, and for the second year by November 30, 2011."

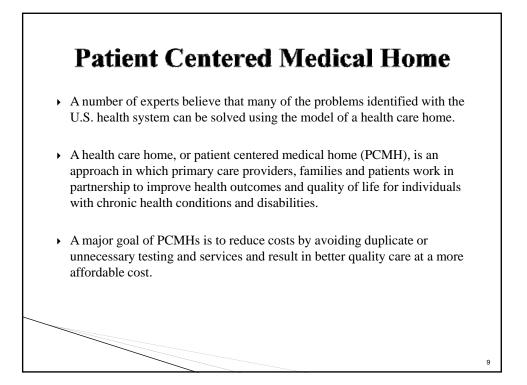


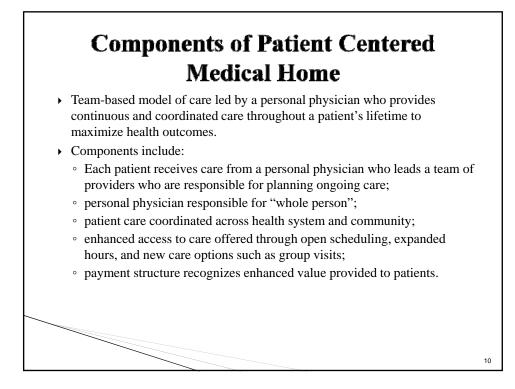


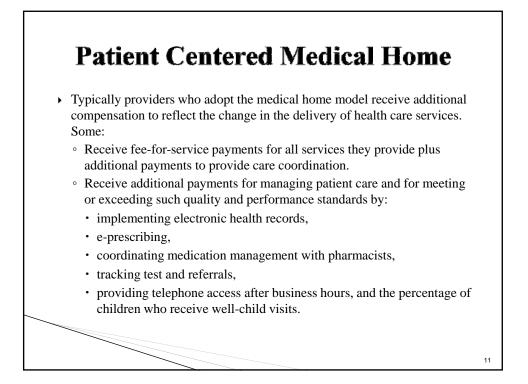


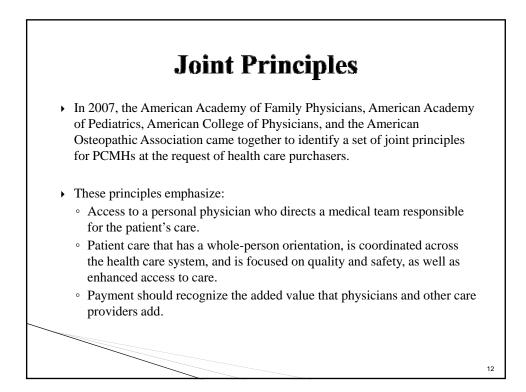














- Standards developed by the National Committee for Quality Assurance (NCQA) are most often used to identify which primary care practices have achieved designation as a medical home.
- The standards allow for recognition as a PCMH at 3 different levels and include 30 elements, of which 10 are considered mandatory or "must pass."
- Practices that achieve NCQA's PCMH Recognition are positioned to take advantage of financial incentives offered by health plans and employers, as well as of federal and state-sponsored pilot programs.

• NCQA updated its standards and published new guidelines in January 2011.

13

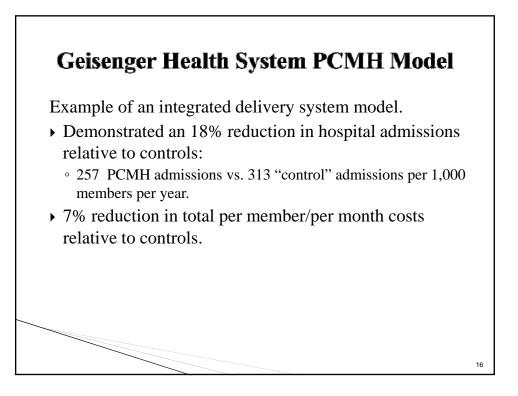
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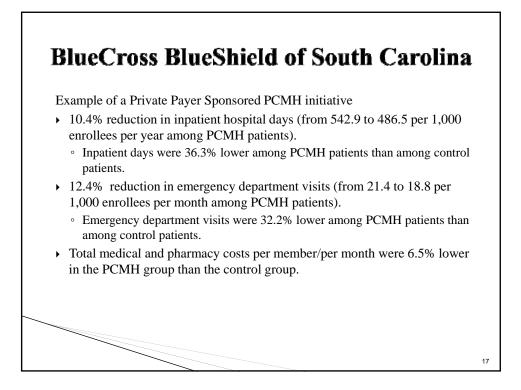
Patient-Centered Primary Care Collaborative (PCPCC) Pilot Programs

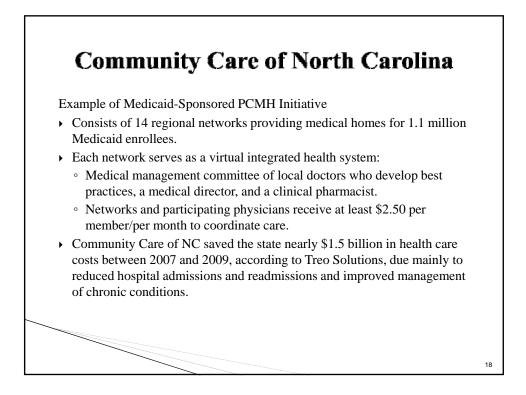
The PCPCC recently released a report that summarized findings from PCMH demonstrations and concluded that "investing in primary care patient centered medical homes results in improved quality of care and patient experiences, and reductions in expensive hospital and emergency department utilization...Several major evaluations show that patient centered medical home initiatives produced a net savings in total health care expenditures for the patients served by these initiatives.

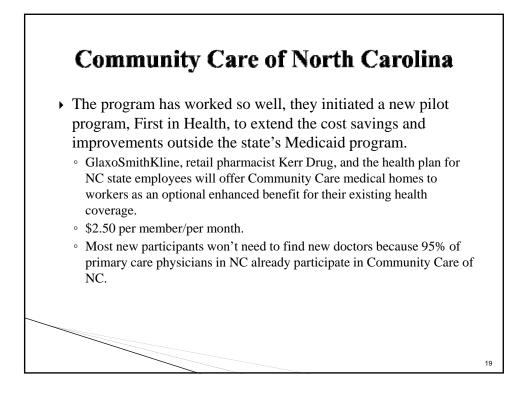
• Studies have demonstrated that PCMHs improve access and reduce unnecessary medical costs.

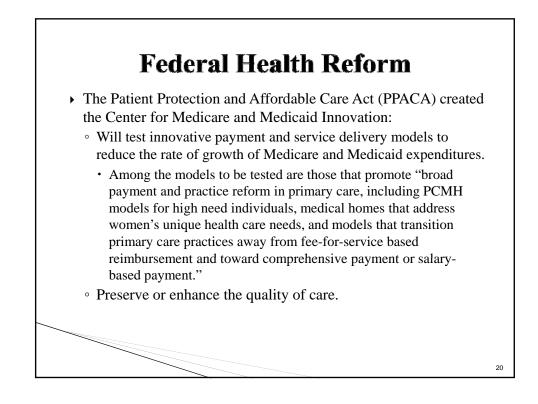
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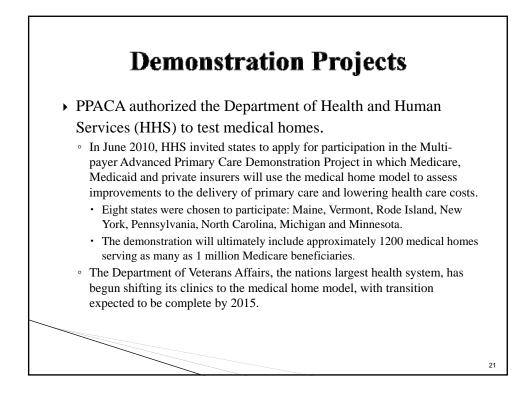


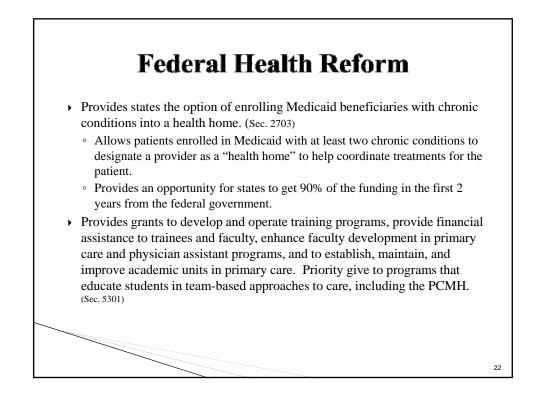


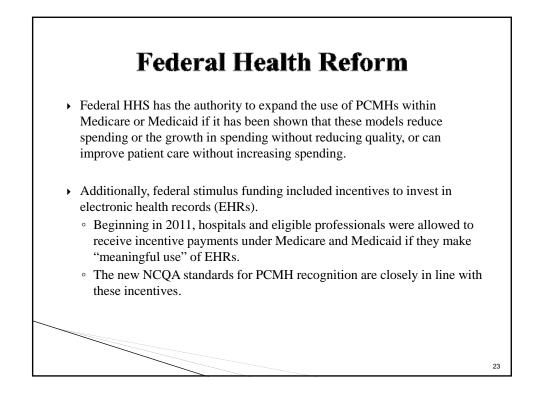












Virginia Department of Medicaid Assistance Services (DMAS)

 DMAS is partnering with the Southwest Virginia Community Health Systems, Community Care Network of Virginia, and Carilion in order to transition a Medicaid primary care case management program in southwestern Virginia into a medical home pilot.

• The medical home pilot, which received a technical assistance grant from the National Academy of State Health Policy and the Commonwealth Fund, will provide primary care, behavioral health, disease and case management, and other services.

24

