



# **What Is a Medical Home Anyway and Where Did It Come From??**

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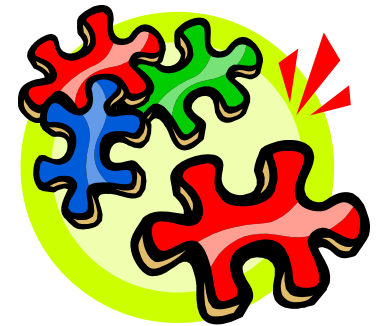
# Origins of Medical Home

- AAP - introduced the “medical home” in 1967 as way to improve the care of children with special health care needs, (CSHCN) estimated as 13–18% of children.
- CSHCN account for 80% of pediatric health care expenditures
- >50% of families cut back on work or stop working due to child’s or youth’s condition

# AAP Medical Home Elements:

Care that is:

- Accessible
- Family-centered
- Continuous
- Comprehensive
- Coordinated
- Compassionate
- Culturally effective



and for which  
the PCP:

Shares Responsibility with  
Patient/Family



# Origins of Medical Home

1978 –WHO endorsed central role of primary care

- first-contact care
- responsibility for patients over time
- comprehensive care that meets or arranges patient's health care needs
- coordination of care across a patient's conditions, care providers, and settings



# Primary Care Case Manager

Managed care - PCPs have central care coordinating role, a “primary care case manager” (or pejoratively ) a “gatekeeper,” limiting patients’ access to desired care to save money.

Medicaid, the primary care case management model was more to help recipients gain access to care



# Chronic Disease

- Accounts for disproportionate share of health care expenditures
  - 14% of Medicare patients have heart failure, but account for 43% of spending.
  - ~ 18 % of Medicare patients have diabetes, but account for 32% of spending.



# What's a Pound of Prevention Really Worth?

New York Times 1/24/07

- With the right preventive care, people can cut their risk of a heart attack by up to 80%, cardiologists estimate.
- “We have made major improvements in prevention...but it’s difficult. It takes frequent visits, a close relationship between a physician and a patient and a very committed patient.” (Dr. Gregg W. Stone, Director Cardiovascular Research at Columbia University)



# Chronic Care Model

(Wagner, 2001)

- Primary care–based
- Delivery system change from reactive to proactive model
- Decision support –evidence based guidelines
- Patient self-management support



# Chronic Care Model

- Clinical information systems – tracing and monitoring across disciplines and time
- Links to community resources – encourage healthy living
- Health systems – incentives for quality improvement



# Iowa Medical Home Initiative

- *The purpose of the Iowa Medical Home Initiative is to incorporate the elements of the Medical Home Model as a standard of care in community primary care physician offices in Iowa*



I O W A  
MEDICAL HOME  
*Initiative*

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# History of

## Iowa Medical Home Initiative

The Original Collaborative Partnership (“Promise to the State” 2002 ):

- Child Health Specialty Clinics
- Early ACCESS (IDEA Part C)
- Iowa Academy of Family Physicians
- Iowa Chapter of the American Academy of Pediatrics
- (MCHB grant)



# IMHI

- **Primary goal:**

To create a medical home facilitation model centered around community-based primary care practices

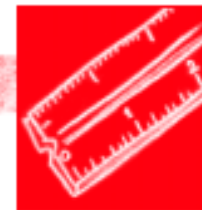
- **Overall goals:**

- Optimize quality of care for CYSHCN
- Improve satisfaction of all
- Assure that the medical home is cost effective.
- Develop sustainable methods of payment for care
- Use an integrated systems approach to medical home implementation.



# IMHI – Phase I

- Individual clinics
- IMHI facilitators met with clinic monthly
  - Fill out Medical Home Index
  - Examine results, develop aims and strategies
  - Learn to use the PDSA cycle of change
  - Patient and staff evaluations
  - Repeat Medical Home Index at end of year



Domain 1: Organizational Capacity: For CSHCN and Their Families

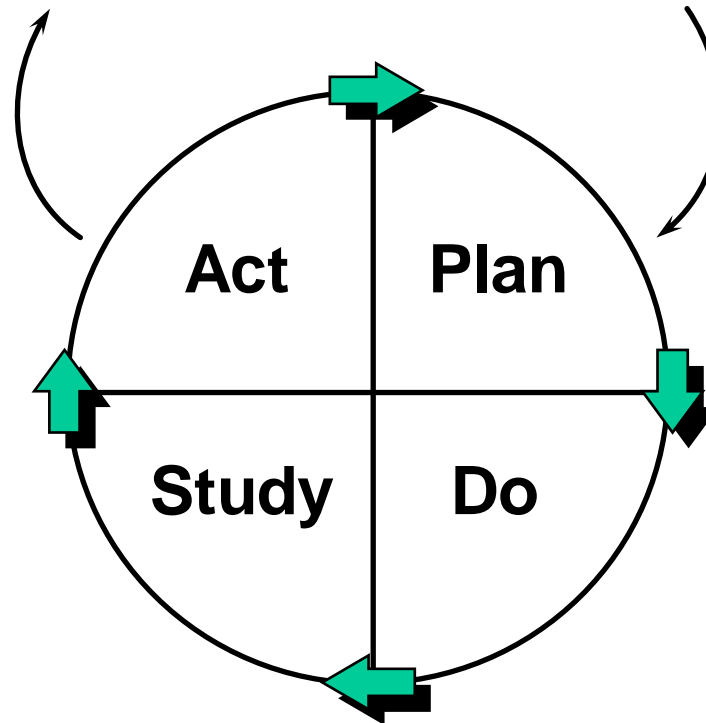
THEME:	<i>Level 1</i>	<i>Level 2</i>	<i>Level 3</i>	<i>Level 4</i>
<p><b>#1.1</b> The Mission of the Practice</p>	<p><i>Primary care providers (PCPs) at the practice have individual ways of delivering care to children with special health care needs CSHCN; their own education, experience and interests drive care quality.</i></p> <p><input type="checkbox"/> PARTIAL <input type="checkbox"/> COMPLETE</p>	<p>Approaches to the care of CSHCN at the practice are child rather than <i>family-centered</i>; office needs drive the implementation of care (e.g. the process of carrying out care).</p> <p><input type="checkbox"/> PARTIAL <input type="checkbox"/> COMPLETE</p>	<p>The practice uses a <i>family-centered</i> approach to care (see page 2), they assess CSHCN and the needs of their families in accordance with its mission; feedback is solicited from families and influences office policies (e.g. the way things are done).</p> <p><input type="checkbox"/> PARTIAL <input type="checkbox"/> COMPLETE</p>	<p>In addition to Level 3, a parent/ practice "advisory group" promotes <i>family-centered</i> strategies, practices and policies (e.g. enhanced communication methods or systematic inquiry of family concerns/priorities); a written, visible mission statement reflects practice commitment to quality care for CSHCN and their families.</p> <p><input type="checkbox"/> PARTIAL <input type="checkbox"/> COMPLETE</p>
<p><b>#1.2</b> Communication/ Access</p>	<p>Communication between the family and the PCP occurs as a result of family inquiry; PCP contacts with the family are for test result delivery or planned medical follow-up.</p> <p><input type="checkbox"/> PARTIAL <input type="checkbox"/> COMPLETE</p>	<p>In addition to Level 1, standardized office communication methods are identified to the family by the practice (e.g. call-in hours, phone triage for questions, or provider call back hours).</p> <p><input type="checkbox"/> PARTIAL <input type="checkbox"/> COMPLETE</p>	<p>Practice and family communicate at agreed upon intervals and both agree on "best time and way to contact me"; in individual needs prompt week-end or other special appointments.</p> <p><input type="checkbox"/> PARTIAL <input type="checkbox"/> COMPLETE</p>	<p>In addition to Level 3, office activities encourage individual requests for flexible access; access and communication preferences are documented in the care plan and used by other practice staff (e.g. fax, e-mail or web messages, home, school or residential care visits).</p> <p><input type="checkbox"/> PARTIAL <input type="checkbox"/> COMPLETE</p>
<p><b>#1.3</b> Access to the Medical Record <i>Requires both MD &amp; key non-MD staff person's perspective.</i></p>	<p>A policy of access to medical records is not routinely discussed with families; records are provided only upon request.</p> <p><input type="checkbox"/> PARTIAL <input type="checkbox"/> COMPLETE</p>	<p>In addition to Level 1, it is established among staff that families can review their child's record (but this fact is not explicitly shared with families).</p> <p><input type="checkbox"/> PARTIAL <input type="checkbox"/> COMPLETE</p>	<p>All families are informed that they have access to their child's record; staff facilitates access within 24-48 hours.</p> <p><input type="checkbox"/> PARTIAL <input type="checkbox"/> COMPLETE</p>	<p>In addition to Level 3, practice orientation materials include information on record access; staff locate space for families to read their child's record and make themselves available to answer questions.</p> <p><input type="checkbox"/> PARTIAL <input type="checkbox"/> COMPLETE</p>

# Model for Improvement

What are we trying to accomplish?

How will we know that a change is an improvement?

What change can we make that will result in improvement?





# Challenges

- TIME – meetings, work on projects between meetings, pilot test tools, develop new tools - discouraged by slow progress
- Overwhelmed by the big picture
- Technology – computer hardware/software



## IMHI Phase II

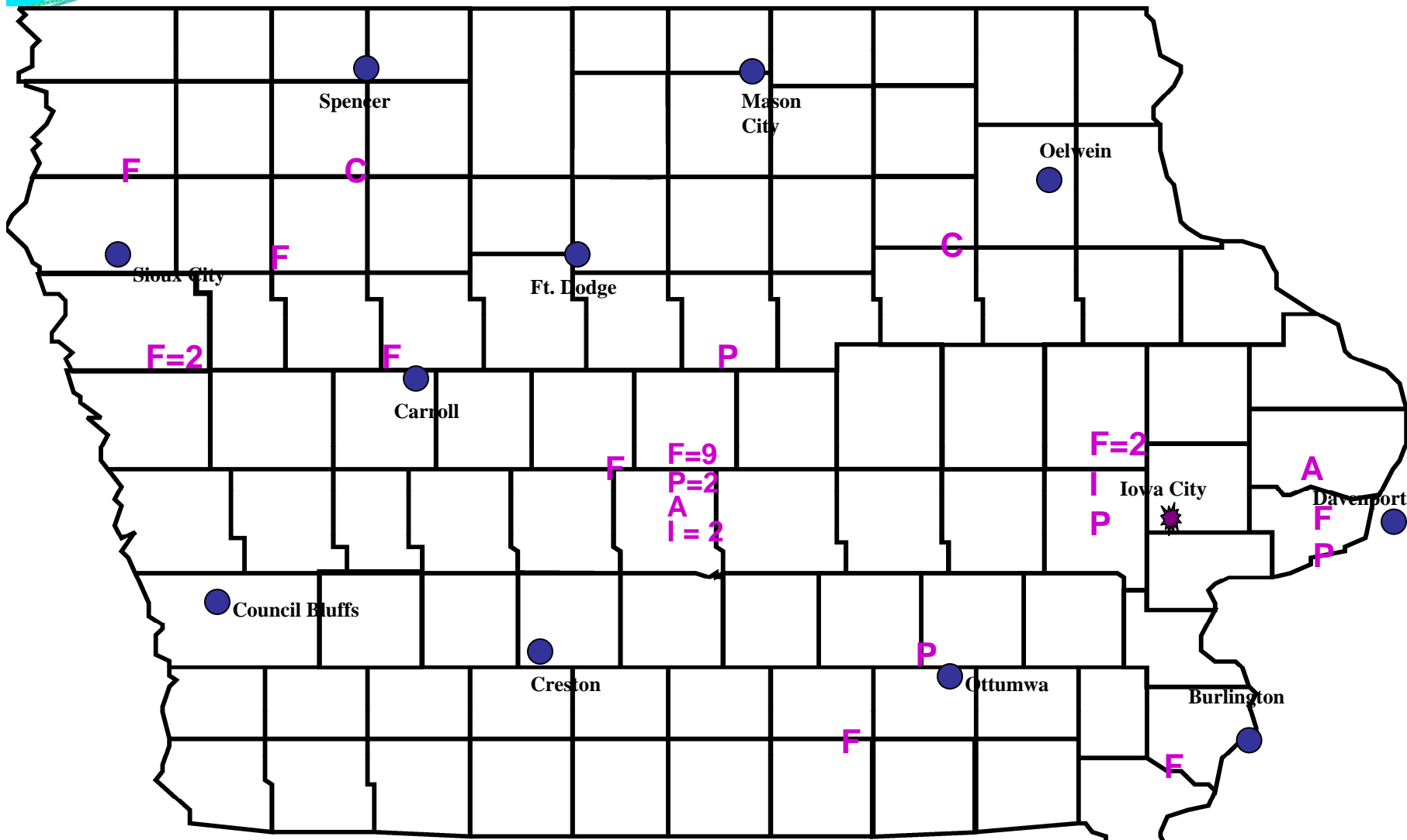
- Partner Clinics – 12, more rural
  - Recruitment challenging – much time spent marketing, meeting, and communicating with clinics. Often took 3-6 months for decision
  - Implemented some changes already piloted by Phase I clinics
  - Facilitators had fewer face to face meetings- quarterly



## IMHI – Phase III

- Need for cost-effectiveness caused change from facilitation model to learning collaborative model
- Intended for faster spread
- Generalized to Chronic Care Improvement
  - More attractive to Family Medicine/ Internal Medicine, 3<sup>rd</sup> party payers, policymakers

# 2006 IMHI Chronic Care Improvement Learning Collaborative Clinics



● **Regional Centers**     
 A = Administrative Team (2)     
 I = Internal Medicine (3)

★ CHSC Central Office     
 C = Community Health Center (2)     
 P = Pediatrics (6)

F = Family Practice (20)

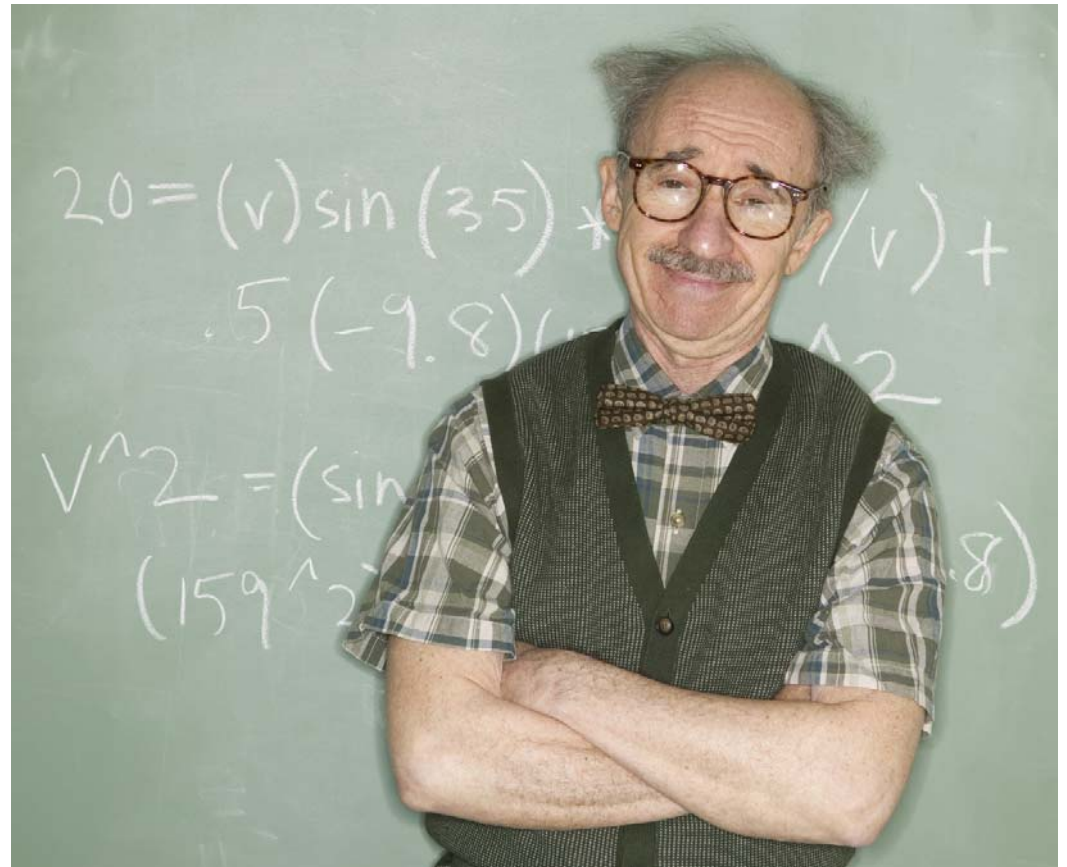


## IMHI Phase IV

- Working closely with IDPH 1<sup>st</sup> Five Healthy Mental Development, providing technical assistance
- Providing education on Medical Home concepts to safety net providers (IANEPCA)
- Provided recommendations re: Training & Certification of practices

# Key Components: What have we learned?

- Use of registry
- Care Coordination
- Care Plan
- Family Participation
- Community Resources





# AAFP - TransforMed

- TransforMED is a new model started in 2006 with core elements:
  - ◆ Patient-centered care
  - ◆ Electronic medical records
  - ◆ Team approach to care
  - ◆ Open access for patients
  - ◆ Focus on quality and safety



## National Committee for Quality Assurance (NCQA): Physician Practice Connections (2006-7)

1. Access and Communication
2. Patient Tracking and Registry Functions
3. Care Management
4. Patient Self-Management Support
5. Electronic Prescribing
6. Test Tracking
7. Referral Tracking
8. Performance Reporting and Improvement
9. Advanced Electronic Communication



# Patient- Centered Medical Home

(2007)

Joint principles of a “patient-centered medical home,”  
consolidating perspectives that the societies had  
developed separately

American Academy of Family Practice (AAFP)

American College of Physicians (ACP)

American Academy of Pediatrics (AAP)

American Osteopathic Association (AOA)



# Joint Principles of PCMH

- **Personal physician** –provides first contact, and continuous and comprehensive care
- **Physician directed medical practice** –leads a team of individuals who take responsibility collectively for the ongoing care of patients.
- **Whole person orientation** –takes responsibility for arranging appropriate care with other qualified professionals. This includes care for all stages of life, including acute care, chronic care, preventive services, and end of life care.



# Joint Principles

- **Quality and safety** are hallmarks of the medical home:
  - 1. Voluntary recognition process to demonstrate that they have the capabilities to provide patient centered services consistent with the medical home model.
  - 2. 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.



# Joint Principles

- **Care is coordinated** across all elements of the health care system and the patient's community
- Care is facilitated by **registries, information technology, health information exchange** to assure that patients get the indicated care when and where they need and want it in a **culturally and linguistically appropriate** manner.



# The Patient Centered Primary Care Collaborative (PCPCC)

- Major employers (50 million employees) wanted to buy high quality healthcare for their employees but couldn't find what they wanted, got together with the providers, patients and the payers, forming a collaborative to design and implement a new system that focuses on primary care and the medical home



# PCPCC

- Focused on the Patient Centered Medical Home (PC-MH)
- Commonwealth Fund's patient-centered care initiative
- How to qualify physician practices and strategies for redesigning the healthcare payment system



# PCPCC

- 22 projects in 16 states
  - 12 multi-stakeholder
  - 10 insurer-based
- 8 State Medicare pilots planned for 2009
- 44 states & the District of Columbia have passed >330 laws or have PCMH activity

# PCPCC Challenges – Define the Medical Home

- Recognition tool
- Independent, 3<sup>rd</sup> party entity
- Alignment with PCMH attributes
- Flexible
- Road map for practices to evolve over time
- Applicable to practices of different sizes



# PCPCC

- Key to implementing - aligning incentives through an enhanced reimbursement system that is structured to allow primary care providers to offer these services.
- Ideally, compensation is a hybrid payment model, integrating a case management fee, or performance-based fee, with traditional per-visit fees.

# PCPCC report from pilot projects

- Cost savings – less ER visits, reduced tests, unnecessary consultations
  - Pennsylvania pilot sites
    - Reduced hospital admissions by 20%
    - Reduced total medical costs 7%
- Patient satisfaction



# National Academy for State Health Policy (NASHP)

- Leading discussions to adopt standards & define metrics associated with providing true medical home
- Working closely with PCPCC's Center for Public Payer Implementation



## NASHP – State Medical Home Scan

- Between January – October 2008 scanned what states doing to advance Medical Home for Medicaid or SCHIP
- Total of 34 initiatives in 31 states

# Medicare Medical Home Demonstration (MMHD)

- 8 states, 3-yr demonstration projects of PCMH
- Authorization
  - Tax Relief & Health Care Act of 2006 (TRHCA), Sect 204
  - Medicare Improvements for Patients & Providers Act (MIPPA) of 2008, Sect 133



# MMHD

- Why?
  - unsustainable cost inflation
  - Some quality of care is suboptimal
  - Some care is fragmented & inefficient



# MMHD structure

- Tier 1: Basic medical home services, basic care management
- Tier 2: Advanced medical home services, full care management fee



# MMHD

- Practices apply January – March 2009
  - Submit self survey tool documenting MH capabilities
- Practices notified May – December 2009
- Physicians enroll eligible patients – mutual obligations, sign MH agreement
- Payments begin January 2010, end December 2012



# MMHD Benefits to Practice

- Care management fee (risk adjusted)
- Share in savings (80% above 1<sup>st</sup> 2%)
- Provide better quality care to patients
- Improved practice work flow
- Improved job satisfaction

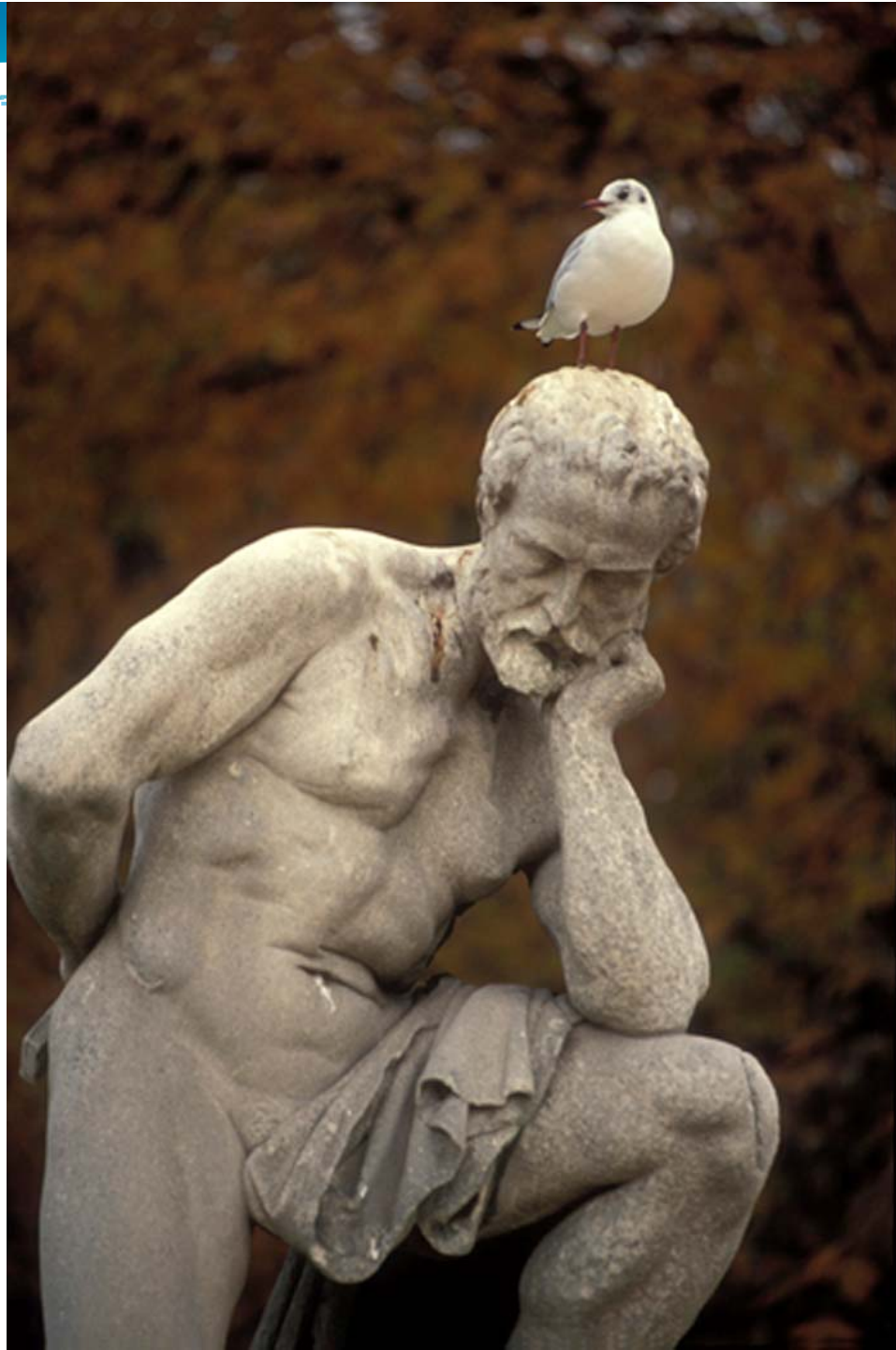


# MMHD Evaluation

- How practices provide medical home services
- Impact of services on:
  - Medicare cost & utilization
  - Quality of care and health outcomes
  - Physician and practices – work flow, costs, satisfaction
  - Patients & families' experience of care

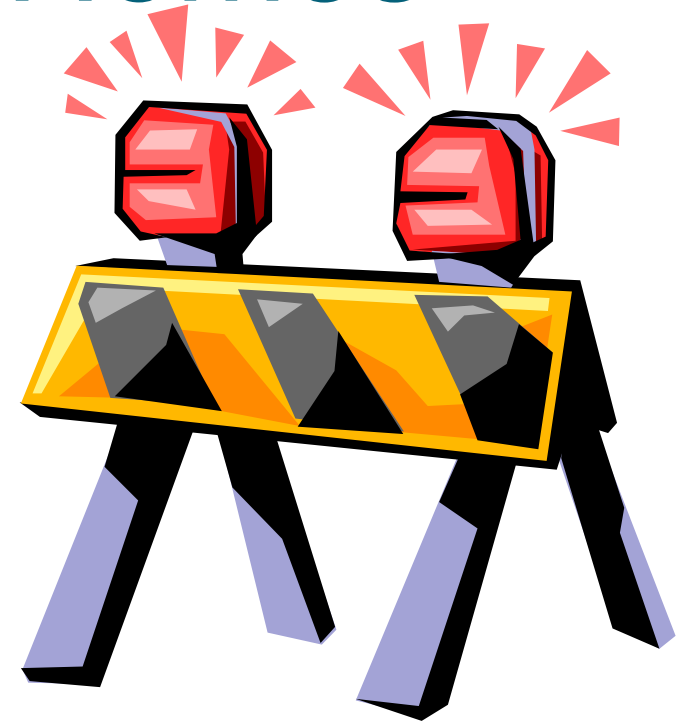
What does the future hold?





# Barriers to Medical Homes

- Time
- Staff
- Resources
- Reimbursement
- Lack of knowledge regarding change
- Unfamiliar with community resources
- Attitude



# Office Attitude

“We already do that!”





# Iowa's high quality and efficiency

- Agency for Healthcare Research and Quality (AHRQ) rates Iowa 4<sup>th</sup> highest in quality
- Dartmouth research rates Iowa as 2nd in efficiency
- Commonwealth Fund study- no state had a higher combination of quality and efficiency than Iowa

Therefore we have the highest value

- AND low pay with the highest Medicare burden!



# Iowa Challenges

- Shortage of physicians: Iowa is 44<sup>th</sup> in the nation in physicians/capita (half as many as Massachusetts)
- Predicted nationwide shortages will make recruitment and retention even worse in Iowa
- Geographic penalties make our situation even worse



# Geographically lower payments

- 80/89<sup>th</sup> in Medicare physician fees (GPCI)
  - Fees are 8% lower in Iowa than US average, 32% lower than California
  - GPCIs make our Medicare fees far lower than other states (and urban areas) since 1992



# Iowa's penalties

- Adding to the burden -Iowa has half as many physicians/capita as in Massachusetts, New York, and Maryland
- 6th highest % of Medicare population
- 2nd highest % of 85+ yr. old population
- Medicare burden– the most Medicare patients per physician



# Web Sites

- Latest legislative reports:  
[www.trendtrack.com/texis/app/viewrpt?event-483e340d37b](http://www.trendtrack.com/texis/app/viewrpt?event-483e340d37b)
- Private sector projects: [www.pcpcc.net](http://www.pcpcc.net)
- Medicare Medical Home Demo link:  
[www.cms.hhs.gov/DemoProjectsEvalRpts/MD/list.asp; medhomedemo@cms.hhs.gov](http://www.cms.hhs.gov/DemoProjectsEvalRpts/MD/list.asp; medhomedemo@cms.hhs.gov)
- NASHP website: [www.nashp.org/index.cfm](http://www.nashp.org/index.cfm)
- Reimbursement models: [www.coloradoguidelines.org](http://www.coloradoguidelines.org)
  - Neg incentives of current system:  
<http://www.aafp.org/fpm/20050500/59then.html>

# The National Center of Medical Home Initiatives

[www.medicalhomeinfo.org](http://www.medicalhomeinfo.org)

[www.medicalhomeimprovement.org](http://www.medicalhomeimprovement.org)



**MEDICAL HOME  
INITIATIVES**

FOR CHILDREN WITH SPECIAL NEEDS