The Patient & Family-Centered Medical Home  May 11, 2009
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CMHI (Center for Medical Home Improvement)
Medical Home

- **1960’s Pediatrics** – centralized medical record

- **1990s Early 2000 Pediatrics** – Medical Home for Children with Special Health Care Needs; for *all* children and youth

- **2007** - Joint Principles of the Patient-Centered Medical Home
  - American Academy of Family Physicians (AAFP)
  - American Academy of Pediatrics (AAP)
  - American College of Physicians (ACP)
  - American Osteopathic Association (AOA)
  - 2008, AMA signed on
The Patient and Family-Centered Medical Home

- Primary care: preventive, acute, and chronic condition care
- Personalized for each patient /family
- Prevents/helps to manage chronic conditions
  - Emphasizes care coordination
  - Use of health information technology/EMR
  - Features consumer conveniences
    - same-day scheduling; secure e-mail communications
- Strengthens the patient-physician-team relationship
  - More time with each patient
  - Develop/use an individualized plan of care.
CMHI defines the medical home as...

- a community-based, primary care setting which provides and coordinates high quality, planned & family-centered:
  - health promotion
  - acute illness care &
  - chronic condition management
Adult, Patient Centered, emphasizes:
- Personal physician/NP/team
- Whole person orientation
- Safe, high quality care
  - Planned, coordinated care
- Enhanced access
- Payment
- Adults with chronic health conditions

Pediatric, Family Centered, emphasizes:
- Personal physician, NP/team
- Family orientation
- Safe, high quality care
  - Planned coordinated care
- Enhanced access
- Payment
- All children, children and youth with special health care needs
Components of Our System

Access

Quality  Cost

Center for Medical Home Improvement
Reforming our system

Coverage

* Care Delivery

Payment Reform

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The Primary Care Medical Home
What does it looks like when...

- **Vertically** - among health care systems/specialists/PCPs/families
- **Horizontally** - among families/community agencies/schools etc ...
- **Longitudinally** - over time
- **Continuously** - continuity of provider and team

When you go there, your experience is...
Evidence Tells Us … Access to Care in a Patient & Family-Centered Medical Home

- Provision of patient & family-centered care increases
- Efficiency & effectiveness increase
- Redundancy reduction

CMHI Research: Care coordination & chronic condition management associated with significant:
- Reduction in utilization (ER, Hospital)
  - Medical Home Outcomes Study, Pediatrics, July, 2009
- Family report: reduction in worry/burden; improved child health status; care of higher quality (partnerships & use of care plans)
  - Enhanced Outcomes for CYSHCN, Jrnl Amb Care Management Summer 2009
How is the Medical Home Measured?

- **Quality Assurance – do you meet standards?**
  - National Committee for Quality Assurance (NCQA)
    - 10 Standards; Levels 1, 2 and 3
    - Basic requirement for many pilots

- **Quality Improvement – where you are on MH continuum**
  - Medical Home Index – (Validation Study 2003)
    - Medical Home *Family* Index & Survey
      - (Pediatric & adult tools; long & short forms)
Support for pediatric transformation leads to 30% improvement overall in 3 years, n=10.
Professional Standards
- Consistent theoretical framework for medical home
- Clear guidance for quality care processes

Central Resource for Technical Assistance, Coaching, & Tools
- Help to carry out; coaching to best practices; great tools & information; help with transparent processes & patient engagement

Policy Development
- Endorsement of primary care, incentives, & technology
- Integrated models support and accountability
- Appropriate Medical Home policy with legislative changes
Nine of 10 Health Care Opinion Leaders Think Fundamental Change Is Required to Achieve Gains in Quality and Efficiency of Care in the United States

Only modest changes are needed—most of the U.S. delivery system operates well 8%
No changes are needed 0%
Not sure 3%

Fundamental change is required in the way most of the U.S. delivery system is organized 89%

Policy Strategies to Improve Health Care Delivery Organization

“How important do you think each of these are in improving health system performance?”

- **Strengthening the primary care system**: 90%
  - Very important: 72%
  - Important: 18%

- **Encouraging care coordination, and the management of care transitions**: 90%
  - Very important: 68%
  - Important: 22%

- **Promoting care management of high-cost/complex patients**: 88%
  - Very important: 62%
  - Important: 26%

- **Encouraging the integration/organization of providers, both within and across care settings**: 82%
  - Very important: 48%
  - Important: 34%

- **Promoting health information exchange networks/regional health information organizations**: 67%
  - Very important: 32%
  - Important: 35%

Source: Commonwealth Fund Health Care Opinion Leaders Survey, April, 2008.
MEDICAL HOME FEVER
Sometimes we are
laying the tracks
in front of the train.
CMHI – The Issues

- Medical Home - opportunity
- The right kind of time and money
- Workforce development/team development
- Patient/family involvement
- Inclusion of children and youth in all efforts
- Supports for practice transformation
- Patient Centered Primary Care Collaborative (PCPCC.net)
- Statewide efforts; State Medicaid Programs; & Safety Net Initiative (led by the Commonwealth Fund)
- Practice Networks – (e.g. Children’s Hospital Boston – PPOC network / BCBS)
- Medicare Demonstration – (pending)
- AAP, ACP, AAFP, AOP – Demonstration Guidelines released 4/29/09: {collaborators; choosing participants; practice support and reimbursement; and project analysis with distribution of results}.
- Multi-stakeholder Pilots
NH Medical Home Activities

- **CMHI Activity Examples:**
  - Keys To The Medical Home (Endowment for Health, 3/7 NH pilot sites)
  - Pediatric Care Plan Oversight Initiative - Children and Youth with Special Health Care Needs
  - Promoting a Medical Home for (CYSHCN) (Special Medical Services)

- **Other - hospital owned practices – seeking NCQA Recognition**
  - DHMC - Regional Primary Care Center (pediatrics and adult)
    - One site in NH Pilot; CIGNA initiative
  - CORE Physician Services (pediatrics and adult)
  - New London Hospital (pediatrics and adult)
  - Alice Peck Day- Robert Mesropian Community Care
  - Others
Growing number of Multi-Stakeholder Medical Home Pilots
Application Process – 2 Year Pilot, Commences June 1, 2009

- 20 applications, 11 chosen, 2 withdrew
- Variation in practice type, geography, ownership
- Represents 39,000 insured members covered, 130 patient visits/year
- **NCQA Patient Centered Medical Home Recognition™** required
- PMPM payment offsets medical home related time and work effort
- Evaluation- rigorous qualitative & quantitative design
  - Satisfaction, utilization, cost, & *quality*
  - RWJF invitation to Maine and NH to apply for evaluation support
Patient & Family-Centered Medical Home
*Across the lifespan for children, youth and adults*

Getting there - Reformed Coverage, Care Delivery & Payment