Medical Home at 25: Where's It Been, Where's It Going?

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Disclosure

- I have no financial interests to disclose in relation to the material that I am presenting today

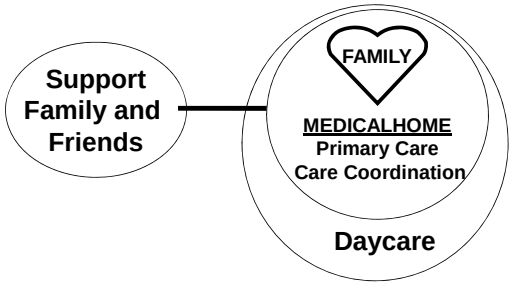
Agenda

- The Family Centered Medical Home
  - A pediatric care innovation
- The FCMH and the Triple Aim
  - Outcomes clear
- A culture of improvement and the experience of 12 high functioning pediatric medical homes

Agenda

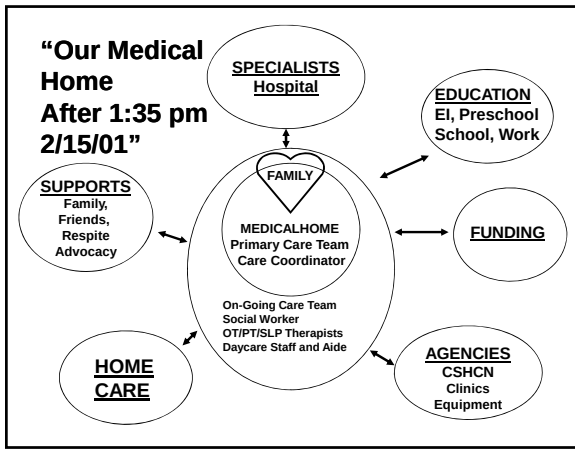
- The road ahead
  - Will we need a new brand name for high quality primary care

Sandy, Parent Partner Burlington, VT: "Our Medical Home until 1:30 p.m. 2/15/01"



"And Then… Along Came the Amazing Miss Kate"

- Congenital Hydrocephalus
- Multiple revisions, infections, complications
- Cerebral Palsy, Epilepsy
- Downright remarkable



Medical Home Transformation

- Timeline
- Outcomes
- Measures and recognition
- A culture of quality improvement

Medical Home Timeline

- Late 1960s
  - AAP uses term "medical home" in reference to centralized pediatric medical records
- Dr. Cal Sia's work in the 80s and early 90s leads to adoption of medical home as a model of primary care by the AAP and the U.S. MCHB

Medical Home Timeline

- 1995
  - U.S. MCHB begins to fund medical home model demonstration projects
- 2002
  - Medical Home Index validated as a quantifiable measure of "medical homeness"

Medical Home Timeline

- 2004 – 2006
  - National Medical Home Learning Collaboratives
    - 2011 – 12 CMHI revisits participants

Medical Home Timeline

- 2007
  - Joint Principles of the Patient-Centered Medical Home published
    - AAP, AAFP, ACP, and AOA

Medical Home Timeline

- 2008
  - First NCQA medical home recognition standards are published (revised in 2011)
  - Regional Medical Home pilot projects

Medical Home Timeline

- 2009
  - Evidence for value of medical home model grows
- 2010
  - Affordable Care Act, CHIPRA, meaningful use

Medical Home Timeline

- 2013
  - ? The Year of the Medical Home

CMHI Defines Medical Home As . . .

- … a community-based primary care setting which provides and coordinates high quality, planned, family/patient-centered health promotion, acute care, and chronic condition management
- Through a process that is satisfying to patients and providers

–CMHI 2008

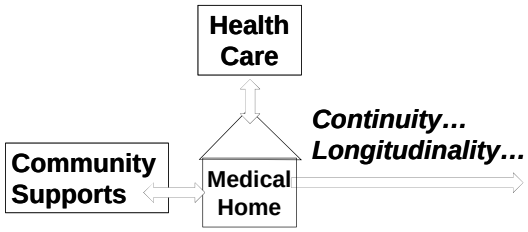
The Primary Care Medical Home Partners with Patient Family at the Crossroads:

- Vertically
  - Among health care systems / specialists / PCPs / others
- Horizontally
  - Among community agencies / schools

The Primary Care Medical Home Partners with Patient Family at the Crossroads:

- Continuity
  - Across providers, settings, episodes of care
- Longitudinality
  - Over time

The Primary Care Medical Home Partners with Patient Family at the Crossroads:



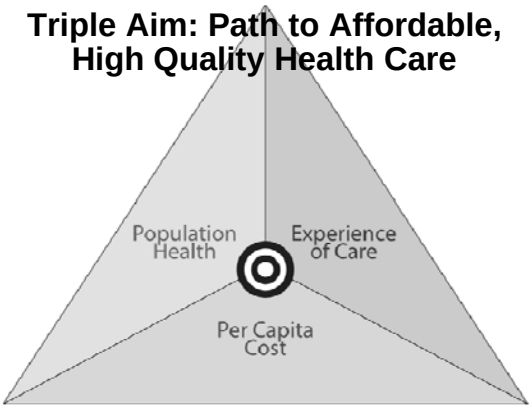
Why Rebrand Primary Care?

- Ratio of primary to specialty care providers
  - U.S. = 30 / 70
  - Other industrialized nations = 70 / 30

Why Rebrand Primary Care?

- Communities in the U.S. with higher concentrations of primary care
  - Lower costs
  - Better population health outcomes
- Decade long decline in career interest in primary care for U.S. physicians in training
  - Just now turning around…

Triple Aim: Path to Affordable, High Quality Health Care



Improved Experience of Care

- Medical Home family surveys
  - Family feedback – 80 families surveyed before and after a three year medical home implementation project
    - ↑ Care plans / summary
    - ↑ Health status

Improved Experience of Care

- ↓ Parental worry
- ↓ School absences
- ↓ ER, hospitalizations, and specialty visits

– McAllister, Sherrieb, Cooley J Amb Care Mgmt, 2009

Improved Population Health

- VA Integrated Service Network (OH)
  - COPD mortality of 10.1/100 patient years vs. 13.8/100 in the usual care group
  - BP control improved from 82% to 86% of patients in the PCMH program compared to 80% of same facility patients not in the program and 76% of VA patients statewide

Improved Population Health

- Intermountain Healthcare (UT)
  - Absolute reduction of 3.4% in 2-year mortality
    - 13.1% died in PCMH group and 16.6% in control group

Reduced Health Care Costs

- Higher overall MHI scores and higher domain scores for:
  - Care coordination
  - Chronic condition management
  - Office capacity
  - Lower hospitalization rates

Reduced Health Care Costs

- Higher chronic condition management domain scores
  - Fewer ER visits

– Cooley, McAllister, Sherrieb, Kuhlthau Pediatrics, July 2009

Measures and Recognition

- Medical Home Index
  - Validated, 25 item scored self-assessment
  - Pediatric and adult care versions
  - Short version

Measures and Recognition

- Widely used
  - Pre and post measure in national and state learning collaboratives
  - Used for medical home recognition in some medical home pilot projects

Measures and Recognition

  - Special version adopted as national measure for all CHIPRA demonstration project
- Health Care Transition Index now available

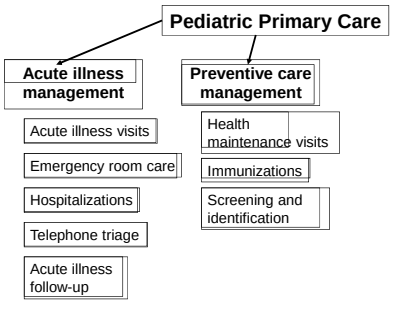
NCQA – Medical Home Recognition

- First available in 2008
- Involves a series of medical home characteristics
  - Includes "must pass" items
  - Requires a portfolio of documentary evidence

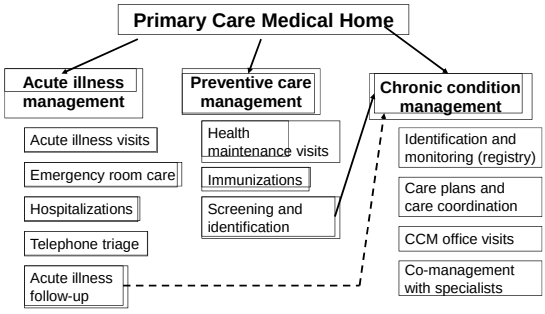
NCQA – Medical Home Recognition

  - Results in score after NCQA review
  - Three levels of recognition
  - Requires payment of a fee to NCQA
- New edition in 2011
- Used to justify prospective payments in some Medical Home pilot projects

The Existing Primary Care Model



The Medical Home Model



A New Culture of Quality Improvement

- Methodology for change
- Learning collaboratives
  - The National Medical Home Learning Collaboratives
- Maintenance of certification

QI – Methodology for Change

- Changing a busy pediatric primary care practice is like changing the tire on a bicycle while you're riding it

"Every system is perfectly designed to get the results that it gets"

– Deming

QI – Methodology for Change

- Change
  - Mindful, intentional, planned, tested, sustained
  - Includes input of those whom it affects
  - Requires a commitment of time and resources

QI – Learning Collaboratives

- Organized approach to quality improvement across multiple settings
- Collaborative learning
  - Shared ideas and innovations
  - Shared data
  - Shared successes

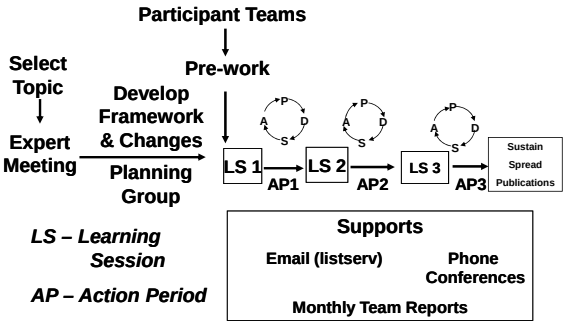
QI – Learning Collaboratives

- Various models
  - Breakthrough Series Learning Collaborative - IHI

The current system cannot do the job. Trying harder will not work. Changing systems of care will.

–Crossing the Quality Chasm - 2001

Breakthrough Series Learning Collaborative Model



Lessons of the National MHLC

- If you do nothing else…
  - Identify your population of CSHCN
  - Gain family participation / feedback
  - Develop the capacity for practice-based care coordination and the use of care plans

During the 1st MHLC

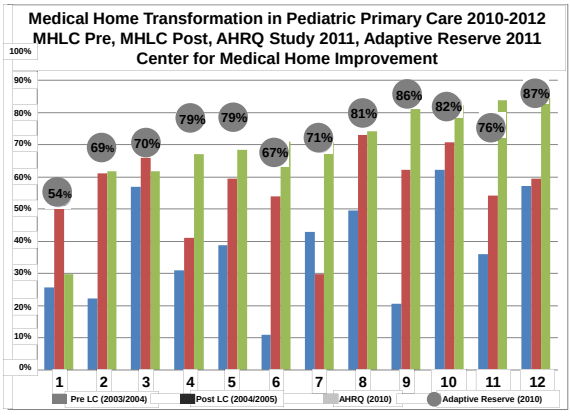
- Title V and primary care partnerships
- Parent partners on 90% of teams
- Identification of CSHCN in 80% of practices
  - 60% enter registry

During the 1st MHLC

- Care coordination
  - 20 / 24 sites with care coordinator
    - 75% budgeted
  - Time dedicated: 20 – 40 hours
- Emergency room visits reduced

Medical Home Transformation in Pediatric Practice

- What drives change?
  - 2 – year AHRQ supported study (2010 – 12)
  - 12 highest-performing pediatric practices from the national medical home learning collaborative in 2004 and 2005



"The Moment of Transformation"

"I think 'medical home' is a process. I don't think it's an endpoint. It is constantly evolving; if you get one thing going, there is always something else you can tweak or improve upon. It should be a way of {practice} life."

– **Pediatrician**

Confusing Labels . . .

- **Medical Home ≠ Health Home**
  - **Well, not usually – but sometimes it can**
  - **Or, when you're in Minnesota or Oregon**

Health Home – According to ACA 2703

- **Delivers a defined set of six services**
- **To Medicaid beneficiaries with specific chronic health or mental health conditions**
  - **Or dually eligible individuals**
- **By a designated provider, team of health professionals, or health team**

Health Home – According to ACA 2703

- **Could be provided by a primary care medical home, but may involve a larger team or a non-traditional health care setting**

Proposed NH CareConnect Health Home Model for Dually-eligible Adults

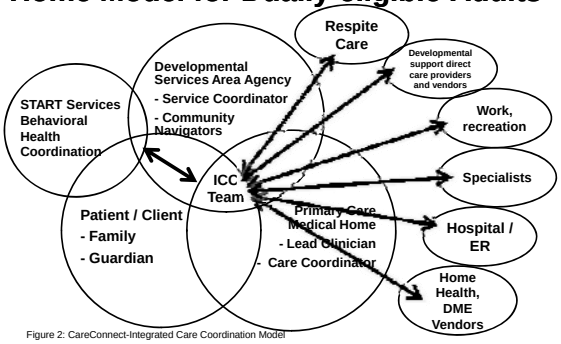


Figure 2: CareConnect-Integrated Care Coordination Model

Integrated Care Organizations Including Accountable Care Organizations (ACO)

- **Provider-led organizations with strong base of primary care**
- **Collectively accountable for quality and costs across the full continuum of care for a population of patients**
- **Payments linked to quality improvements**

Integrated Care Organizations Including Accountable Care Organizations (ACO)

- **Reliable and progressively more sophisticated performance measurement to provide confidence that savings are achieved through improvements in care**

ACOs May Make Medical Home Brand Irrelevant

- **Primary care settings without medical home functionalities will not be able to survive in an ACO environment**
  - **Even with medical home recognition awards**

Necessary Medical Home Functionalities

- **Empanelment**
  - **Relationship with patients and families**
- **Access**
  - **Evening, weekends, holidays, same day**
- **Proactive, health promotion**

Necessary Medical Home Functionalities

- **Co-management with specialists**
  - **Explicit, clear**
- **Coordination of care and services**
  - **Vertically and horizontally**
- **Management of transitions in care**

Necessary Medical Home Functionalities

- **Integrated, high quality information systems**
- **Family engagement in care and improvement**

ACO Members Need . . .

- Organized approach to quality
- Evidence of providing highly efficient care (low cost)

ACO Members Need . . .

- Ability to coordinate care along the continuum
  - With hospitals
  - With specialists
  - With community services
  - With primary care practices

ACO Members Need . . .

- Ability to manage data to measure outcomes for the population served

Future of Medical Home Recognition

- In non-integrated systems of care, primary care must "qualify" for enhanced payments for medical home functionalities
- In integrated systems with global payments (e.g. ACO models), primary care will need medical home functionalities in order to participate

Future of Medical Home Recognition

- Naming this "medical home" or requiring recognition will become unimportant

A Culture of Quality Improvement Will Be Needed for Survival

"When you stop getting better, you stop being good"

–Wyatt Taylor, North Carolina Summer Camp Director

Home is the place where, when you have to go there, they have to take you in.