Advancing the Medical Home

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www.medicalhomeimprovement.org
CareShare-CMHI.org
The mission of CMHI is to promote high quality primary care in the medical home & secure health policy changes critical to the future of primary care.

- Education/Development
- Improvement
- Research
- Policy
In one word or phrase, related to medical home...

- What is one question you want answered or concept you need a better explanation for today?
Health care today…

- Specifically primary care…what do you think? Is everything okay?
Frustrated, idealistic doctor must shutter practice
Economics make solo office a challenge

By Margot Sanger-Katz
Monitor staff

October 07, 2006 8:00AM

Matt Masewic opened Boscawen Family Practice two years ago with dreams and a plan. He had ideals about the kind of medicine he would practice. His independent practice would provide a service to the community - no rejecting patients without insurance, no 10-minute, rushed visits.

He also knew that finances would be tough. He brought in his brother to help him renovate the modest office he rented from the town, bought used equipment and furniture, and hired a bare-bones staff. He figured that this combination of frugality and quality medicine would help his practice.
Box Store Clinics
Concierge practices
Other Innovations?

Concord Monitor

Ken Williams / Concord Monitor
Dr. Michael Stein of Hampstead has reduced his overhead from $300,000 to $50,000 by opting out of taking insurance.
Family medicine positions and the number filled by US medical school graduates

- **Positions Available**
- **Positions Filled**

### Positions Available
- 1994: 2774
- 1995: 2941
- 1996: 3137
- 1997: 3262
- 1998: 3293
- 1999: 3265
- 2000: 3206
- 2001: 3096
- 2002: 2983
- 2003: 2940
- 2004: 2884
- 2005: 2782
- 2006: 2727

### Positions Filled
- 1994: 1850
- 1995: 2018
- 1996: 2276
- 1997: 2340
- 1998: 2179
- 1999: 2024
- 2000: 1833
- 2001: 1516
- 2002: 1413
- 2003: 1234
- 2004: 1198
- 2005: 1132
- 2006: 1132

Bodenheimer, NEJM Aug 06
Not choosing primary care...

- Loan repayment
- Life style concerns
- Work satisfaction
- Second class status
- Isolation
Medical Home as *the* quality model
21st century primary care

- A medical home is a community-based primary care setting which provides and coordinates high quality, planned, patient/family-centered:
  - health promotion (acute, preventive)
  - chronic condition management

CMHI 2006
The Old Primary Care Model

Primary Care

Acute illness management
- Acute illness visits
- Emergency room care
- Hospitalizations
- Telephone triage
- Acute illness follow-up

Preventive care management
- Health maintenance visits
- Immunizations
- Screening and identification
The Medical Home model

Primary Care Medical Home

Acute illness management
- Acute illness visits
- Emergency room care
- Hospitalizations
- Telephone triage
- Acute illness follow-up

Preventive care management
- Health maintenance visits
- Immunizations
- Screening and identification

Chronic condition management
- Identification and monitoring (registry)
- Care plans and care coordination
- CCM office visits
- Co-management with specialists

Acute illness management
- Acute illness visits
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Preventive care management
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Chronic condition management
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- CCM office visits
- Co-management with specialists
Medical Home

- Decision is not whether to become a medical home, but ... how great a medical home to aim for?
What we know is needed

- Access to high quality care processes
- Re-design of care
  - Consumer/family input/feedback
  - Team-based *planned* care/care coordination
- Information technology
  - Registries (population), EMR, decision support systems
  - Transparent, public quality data
- Reinforcements for quality
  - (remove disincentives)
### Care Model for Health in a Medical Home

| Community | • Coordinated linkages with community contacts  
|           | • Provision of resource guidance  
|           | • Population health view |
| Health System | • Align primary care quality standards w/senior leaders  
| | • Partner w/plans for value, measurement, and reimbursement of medical home quality |
| Care Partnership Support | • Engage patients, families in relationship-centered care  
| | • Ensure access (technology, hours, open access) |
| Delivery System Design | • Offer team care w/planned visits/pre-visit assessments & care plans (electronic/portable)  
| | • Provide practice-based care coordination |
| Decision Support | • Identify/use evidence based practice guidelines  
| | • Establish co-management processes w/specialists |
| Clinical Information Systems | • Identify patient populations; stratify by complexity  
| | • Develop and enter into a registry (EMR if possible) |

#### MACROSYSTEMS
- Health Policy
- Health Systems
- Professional Chapters/organizations

#### MICROSYSTEMS: Care Processes
1. Patients/Families
2. Population/need
3. Planned care
4. Practice-based primary care coordination
5. Quality Imp.
CMHI – Care Processes for Health in a Medical Home

- Accessible care
- Planned care
- Coordinated care
- Community-based care
- Patient/family-centered care
- Quality care
Significant outcomes:
Child/ Family Pre/ Post
(p-value of <0.05)

- ↓ ER, hospitalizations, & specialty visits
- ↑ Family feedback
- ↑ Care plans/summary
- ↑ Health status
- ↓ Parental Worry
- ↓ School absences
Medical Home - CMHI National Study
Medical Home Index; 45 Practices, 6 Plans/States
Positive utilization/cost outcomes

- Medical Home Index
  - Chronic condition management (high)
  - Care coordination (high)
    - ↓ Hospitalizations*
    - ↓ Emergency room use
    - ↓ Specialty care (trend)
- Family Data (pending)

*Statistical significance (p-value of <0.05)
Promising practices - Aligning medical home efforts

- Joint Principles of the Patient-Centered Medical Home
- Patient Centered Primary Care Collaborative (ERISA)
- Advanced medical home demonstrations (private payers)
- Medicare, (Medicaid) legislative initiatives
- Payment Models:
  - P4P, Medical Home Prospective/P4Q, Fee for Service
  - Care coordination emphasis
    - Care plan oversight (99339, 99340); prospective payment
    - Chronic condition management (99354 – 99359 codes):
      prolonged physician services with/without patient contact
Joint Principles of the Patient Centered Medical Home: AAFP, AAP, ACP, & AOA

- Patient Centered Medical Home (PC-MH) is an approach to providing comprehensive primary care for children, youth and adults.

- PC-MH is a health care setting that facilitates partnerships between individual patients and their personal physicians and when appropriate, the patient’s family.
The Patient-Centered Medical Home BCBSA Demonstration Project-Proposed Framework

Practice Requirements – Measures for Different Levels

- Measures of NCQA PC-MH:
  - Care coordination
  - Process redesign
  - HIT

- Clinical process and outcome measures
- Measures of resource use & cost of care (TBD)
- Patient, physician and plan satisfaction
The Patient-Centered Medical Home BCBS-A Demonstration Project - Proposed Framework

- **Level 1 (Basic):** Prospective compensation (shifting from FFS) begin some pay for quality (P4Q)

- **Level 2 (Basic+ and Intermediate):**
  Compensation more prospective payment, less FFS

- **Level 3 (Advanced):**
  Full attainment of the PC-MH model.
The Patient-Centered Medical Home BCBS Ass
Demonstration Project-Proposed Framework

- **Level 1 (Basic):** Prospective compensation (shifting from FFS) begin some Pay for Quality (P4Q)
  - Longitudinal care w/ population approach – paper or electronic
  - Proactive use of information – planned care
  - Significant structural and care coordination changes have begun
The Patient-Centered Medical Home BCBS-A Demonstration Project-Proposed Framework

- **Level 2 (Basic+ and Intermediate):**
  Compensation more prospective payment, less FFS
  - Increased ability to provide care coordination (over L1)
  - Additional investment in structural changes (e.g., HIT, >L1)
The Patient-Centered Medical Home BCBS-A Demonstration Project-Proposed Framework

- **Level 3 (Advanced):** Full attainment of the PC-MH model.
  - *(Perhaps)* 50%+ reimbursement derived prospectively - some FFS supplement w/enhanced P4Q based on practice ability to report robust clinical data - electronically.
<table>
<thead>
<tr>
<th>NCQA’s PC-MH Physician Practice Connections Evaluation</th>
<th>NCQA’s PC-MH Physician Practice Connections Care Coordination Process Redesign Health Information Technology</th>
<th>Clinical Process and Outcome Measures</th>
<th>Resource Use Cost of Care</th>
<th>Satisfaction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recognized - Level 1 (Basic)</td>
<td>*25 – 49 points, which practices can achieve by using the simplest information systems (usually just a practice management system) and organizing their information for good care management processes</td>
<td>*Practice chooses 1 condition to report</td>
<td>To be determined</td>
<td>Physician, Patient and Plan satisfaction measured</td>
</tr>
<tr>
<td>Recognized - Level 2 (Intermediate)</td>
<td>*50 – 74 points for achieving 6 modules in PPC v. 1</td>
<td>*Practice chooses 2 conditions to report</td>
<td>To be determined</td>
<td>Physician, Patient and Plan satisfaction measured</td>
</tr>
<tr>
<td>Recognized - Level 3 (Advanced)</td>
<td>*75 – 100 points for achieving all nine current modules of PPC v. 1</td>
<td>*Practice choose 3 or more conditions to report</td>
<td>To be determined</td>
<td>Physician, Patient and Plan satisfaction measured</td>
</tr>
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We set out forming a collaborative to design and implement a new system – one that focuses on primary care and the medical home.
Medical Home Improvements – New Hampshire

- **Primary care viability**
  - Network of improving primary care practices
  - NH Council-Future Primary Care Medical Home (‘07) →
  - Primary Care Task Force – Supports (Endowment for Health)
  - Inclusive Stakeholders – Consumers, CHI, DHMC Leadership, etc

- **Align expectations, language, efforts**

- **Negotiate common demonstration & fiscal supports**
  - (P4P, F4S, MH-admin fee, CC/Care Plan Oversight)

- **Linking to national endeavors**
  - Feedback, feed forward information loop
Care Plan Oversight
(99339, 99340 or Prospective Payment)

- Prospective $225 annual payment per child with special health care needs (CSHCN)
- Practice & care plan criteria:
  - Work w/Center for Medical Home Improvement
  - Use Medical Home Index & Demonstrate:
    - Engaged families in care/improvement
    - Identified population; complexity assigned
    - Delivery of chronic condition management
    - Development and use of a dynamic care plan
Plans – Steps to foster medical home progress

- Use “medical home” language
- Promote clear education related to medical home and quality
- Enable practice improvement by offering technical assistance (re: medical home care processes)
- Offer incentives for quality care processes in a medical home
Home is the place where
When you have to go there
They have to take you in