Medical Home is Quality Practice

2007 Medical Home Summit
Waukesha, Wisconsin
November 15, 2007

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Center for Medical Home Improvement (CMHI)

- 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
Medical Home is *the* quality model for 21st century primary care

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

CMHI 2006
Medical Home

- Decision is
  - not *whether* to *become* a medical home, but … how good or great a medical home you to be?

- Task is
  - Prepare yourselves by developing and demonstrating your medical homeness
  - The rewards for preparation are in the pipeline
If you have not done so already...

- Declare your practice to be a medical home
  - Poster in the waiting room
  - Flyer or brochure
  - Medical home topic on staff meeting agenda
  - Invite comments from youth and families
The crisis for primary care
Primary care as less attractive career

- Debt burdens
- Life style concerns
- Professional satisfaction issues
  - Focus on quantity over quality
  - Poor role definitions
  - Fragmentation of care
- 56 unfilled primary care positions in NH
Proportion of 3rd-Yr Internal Medicine Residents Choosing Careers:

- General Internal medicine
- Subspecialty
- Hospitalist

Bar chart showing the proportion of residents choosing careers from 1998 to 2005.
Family Medicine Positions & # Filled by US Medical School Graduates

- Positions Available
- Positions Filled
Dr. Michael Stein of Hampstead has reduced his overhead from $300,000 to $50,000 by opting out of taking insurance.
Boscawen

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
“Your oil’s fine, but your blood-sugar level’s a little low.”
Medical home for whom...

- All of us
- All children
- All ages
- Need to team up with other primary care colleagues to promote medical home
- But, chronic condition management remains the central to medical home improvement
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
Medical Home – coordinating care:

- Vertically - within health care system and with specialists
- Horizontally - among community agencies and resources

Health care system

Community Supports

Medical Home

Community Supports
Building medical homes...

- **Microsystem**
  - Individual physician and practice
  - Consumers – patients, families

- **Macrosystem**
  - National professional organizations
    - Joint statement on the medical home
  - Medicaid and payer organizations
  - Employers
  - State and federal initiatives
Microsystem - individual practices

- Quality improvement and learning collaborative activities
- Early adopters of key MH elements
  - CYSHCN registries
  - Planned care for CYSHCN
    - Individual care plans
    - Planned co-management with specialists
    - Planned CCM visits
  - Care coordination
    - Designated care coordinator
    - Business plan for care coordination
  - Mechanisms for family/patient feedback
    - Parent advisory groups
    - Patient surveys
    - Parent participation in quality improvement effort
Microsystem - individual practices

- Change facilitators
  - Leadership/organizational support
  - Change methodology – e.g. quality improvement
  - Reimbursement/financing strategy
  - Electronic health record
  - Use of practice-level quality indicators
Microsystem - individual practices

- Change obstacles
  - Absence of existing structure – e.g. staff meetings
  - Limited support/definition of care coordination
  - Belief that no business model is possible
  - Absence of consumer involvement
Microsystem - individual practices

Exeter Pediatrics
- 6 pediatrician, 3 PNP practice
- 2000 CSHCN in registry
- Full-time care coordinator – social worker
- Individual written care plans
- Community outreach coordination
- Dramatically lower ER and hospitalization results compared to 10 other NH practices and to a national sample of 35 other practices for 6 chronic conditions
### Exeter Pediatrics utilization rates compared to 10 NH pediatric practices

<table>
<thead>
<tr>
<th>Practice name</th>
<th>Overall ER visits rate</th>
<th>Overall hospitalization rate</th>
<th>Overall primary to specialists ratio</th>
<th>Total # of children</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exeter Pediatrics</td>
<td>4.74</td>
<td>0.68</td>
<td>1.29</td>
<td>443</td>
</tr>
<tr>
<td>Anthem mean (n=11)</td>
<td>6.13</td>
<td>1.06</td>
<td>0.86</td>
<td>226.7</td>
</tr>
</tbody>
</table>

Rates are per 100 children with 6 chronic conditions (asthma, diabetes, CP, epilepsy, ADHD, autism)
Microsystem - individual practices

- Chapel Hill Pediatrics
  - 6 FTE pediatricians (11 physicians)
  - 900+ CSHCN in registry
  - Care coordinator increased from 3 hr/week to full-time
  - Physician training for coding of CSHCN CCM visits
  - 50% fewer ER visits for BCBS patients compared to aggregate of other area practices
    - 3 year savings to BCBS of >$112,000
    - Used to re-negotiate reimbursement
Macrosystem – national professional organizations

- **Joint Principles of the Patient-Centered Medical Home**
  - AAP, AAFP, ACP, and AOA – 330,000 physicians
  - Endorses medical home as defining highest quality primary care

- **Advanced Medical Home Model**
  - 3 or 4 stages of primary care practice
    - Basic, Basic+, Intermediate, Advanced Medical Home
    - Re-imbursement options increase at higher stages
    - Piloting concept with large health plans
Macrosystem – payer organizations

- Anthem – CMHI care plan oversight pilot
  - NH practices meet “medical home” criteria determined by Anthem
  - CSHCN identified using screener
  - Practices develop/document care plan for each CSHCN with at least annual update
  - Anthem activates care plan oversight code
    - Reimburse practice annual prospective payment - $225.00
  - Track utilization for patients involved
Macrosystem – employers

- **ERIC – ERISA Industry Committee**
  - National organization representing the employee benefits interests of major corporations
  - IBM, Boeing, Dell, FedEx
  - Patient-centered Primary Care Collaborative
    - Coalition of major employers, consumer groups, organizations representing primary care physicians
    - Advancing the patient centered medical home
    - To improve the health of patients and the viability of the health care delivery system.
  - [www.eric.org](http://www.eric.org)
  - Meetings and weekly conference calls
We set out forming a collaborative to design and implement a new system – one that focuses on primary care and the medical home.
Macrosystem – state/federal initiatives

- Every child with special health care needs will receive comprehensive, coordinated care in a medical home by 2010 – New Freedom Initiative

- Medicare Medical Home Demonstration Project – Tax Relief and Health Care Act of 2006
  - Physicians receive a care management fee for patients with chronic condition enrolled in project
  - Physicians receive 80% of cost savings due to reduced Medicare expenditures

- Possible Medicaid legislation for medical home pilot projects
Macrosystem – national research agenda

- NICHD – NIH new research agenda
- Providing a Medical Home for children following life-threatening illness or injury
  - Continuum of care from medical home to ED to PICU to acute hospital to rehab to home
  - Focus on care coordination and communication between levels of care in the continuum rather than on care within a particular level of care
Wellness Care

Family Supports

Mental health

Early Intervention

School

VNA

Care Coordination

Primary Care Medical Home

Emergency Department

Rehab Hospital

Acute Hospital

PICU

Care During Life-Threatening Illness or Injury

Family Centered Care

Family Child Youth

CMHI
Building medical homes requires…

- Practice level change
  - Individual – quality improvement
  - Multiple – learning collaboratives
  - Widespread adoption – turn-key tools and incentives

- Endorsement of medical home as best practice

- Engagement of leadership and partnerships
  - Practice organizations and networks
  - Payers
  - Industry leaders
  - Policy makers
Building medical homes requires...

- Support for health information technology

- Data showing improved medical home outcomes
  - Clinical
  - Functional (child and family)
  - Satisfaction (patient and provider)
  - Cost

- Financing and reimbursement
  - New reimbursement models
    - Fee for service enhancements
    - Prospective payments
    - Pay for quality
Home is the place where
When you have to go there
They have to take you in