Medical Home Building and Implementation for Primary Care: No Child Left Behind

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Disclosure

- I have no relevant financial relationships with the manufacturer(s) of any commercial products(s) and/or provider(s) of commercial services discussed in this CME activity.
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MEDICAL HOME Implementation for Primary Care

- Military System of Care
- Definition of Medical Home
- NCQA
- Providence Pediatrics approach
- Quality Improvement
Military system  (British Model of Care)
- 9.6 million beneficiaries total
  - 5.4 million
  - 3.7 million direct care system
  - 1.7 million contractor networks
  - 5.1 TRICARE Standard/Extra
- Beneficiaries
  - Active duty 5.1 million
  - Active duty families 3.1 million
  - Veterans 1.6 million
  - Retirees 1.0 million
- Quaduple-Aim (BH aims)
  - Experience of Care
  - Population Health
  - Per Capita Cost
  - Readiness (Unique to the Military System)
- Using NQfA for measurement of Medical "Hominess"
- Rotating patients and providers

MEDICAL HOME DEFINITION
- Primary care
- Family-centered partnership
- Community-based, interdisciplinary approach to care
- Care that is: accessible, family-centered, coordinated, compassionate, continuous, comprehensive and culturally effective.
- Preventive, acute and chronic care
- Quality improvement

MEDICAL HOME JOINT PRINCIPLES
- Personal physician
- Physician directed medical practice
- Whole person orientation
- Care is coordinated and/or integrated
- Quality and safety are hallmarks of a medical home
- Enhanced access to care
- Payment appropriately recognizes the added value
“Four Pillars of Primary Care

- Access to first contact care
- Coordinated care
- Comprehensive Care
- Sustained personal relationships

PATIENT CENTERED PRIMARY CARE COLLABORATIVE (PCPCC)

- Coalition of major employers, consumer groups, organizations representing primary care physicians and other stakeholders who have joined to advance the patient centered medical home.
- Examples of Membership in the Collaborative:
  - National Business Group on Health
  - General Motors
  - IBM
  - AAP, ACP, AAFP and AOA

Patient/Family-Centered Care

- Having activated, engaged patients/families who want better service and transparency in health care and seek to form partnerships with health care practices.
- Patients/Families are asking for the care they want and need, when and how they want and need it, as well as for access to information to make appropriate choices.
NCQA: PATIENT CENTERED MH MEASUREMENT

- PCMH 1: Enhance Access and Continuity
- PCMH 2: Identify and Manage Patient Populations
- PCMH 3: Plan and Manage Care
- PCMH 4: Provide Self-Care and Community Support
- PCMH 5: Track and Coordinate Care
- PCMH 6: Measure and Improve Performance

NCQA ACCREDITATION FOR MEDICAL HOME

- **Level 1**: 35–59 points and all 6 must-pass elements
- **Level 2**: 60–84 points and all 6 must-pass elements
- **Level 3**: 85–100 points and all 6 must-pass elements

NCQA ACCREDITATION

- **The Must-Pass Elements**
  - Six must-pass elements are considered essential to the patient-centered medical home, and are required for practices at all recognition levels. Practices must achieve a score of 50% or higher on must-pass elements:
    - 1. PCMH 1, Element A: Access During Office Hours
    - 2. PCMH 2, Element D: Use Data for Population Management
    - 3. PCMH 3, Element C: Care Management
    - 4. PCMH 4, Element A: Support Self-Care Process
    - 5. PCMH 5, Element B: Track Referrals and Follow-Up
    - 6. PCMH 6, Element C: Implement Continuous Quality Improvement
THE MEDICAL HOME IN PEDIATRIC PRACTICE
- Providence Pediatrics
- Data Collection
- Care Coordination
- Family-Centered Care

Providence Pediatrics North
- Spokane Medical Community
- Four Pediatricians
- Three Mid-level providers
- Office Staff of 15 FTE's
- Approx. 9,000 patients
- 1000 CYSHCN

MID-LEVEL PROVIDERS
- Nursing background
- Parents of CYSHCN
- Lower costs
- Timeline to train
- Liability
DATA COLLECTION

- Data person
- Excel spreadsheet/Access
- Disease specific data collection
- ICD 9 Codes
- Questionnaires
- Diagnosis, Ages, Severity, Insurance

DIAGNOSIS - CYSHCN

SEVERITY
INSURANCE COVERAGE

CARE COORDINATION
- Office coordinator
- Inservice presentations
- Care Plans
- Specialty follow up
- Chronic Care visits
  - Pre visit
  - Post visit
  - Reminder system

FAMILY CENTERED CARE
- Family is the constant in the care of the patient
- Connecting families
  - Newsletter
  - Bulletin board
- Asking families/surveys
BENEFITS OF MEDICAL HOME

- Increased patient and family satisfaction
- Lower costs
- Lower out of pocket costs for families with CYSHCN
- Efficient use of limited resources
- Reduced health disparities
- Improved professional satisfaction

Evidence in Support of the Medical Home

- Increased vaccine rates
- Increased patient and provider satisfaction
- Increased completeness of anticipatory guidance and wellness care
- Improved efficiency and effectiveness
- Primary care/medical home lowers health care costs

CROSSING THE QUALITY CHASM – A NEW HEALTH CARE SYSTEM FOR THE 21ST CENTURY

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

- “Improved performance will depend on new system designs.”
PRIORITY AREAS FOR NATIONAL ACTION – TRANSFORMING HEALTH CARE QUALITY

- “Behind each of the priority areas recommended in this report is a patient who may be receiving poor quality care. This is due not to a lack of effective treatments, but to inadequate health care delivery systems that fail to implement these treatments.”

CULTURE OF PEDIATRIC PRIMARY CARE

- Designed for the 80% of children who do not have special health care needs
- Designed to provide well child preventive care services and acute illness management
- Designed to support a single service unit: the provider – patient encounter

CHALLENGES TO QUALITY PRIMARY CARE OF CSHCNs

- Offices lack systematic approaches to CSHCNs
- Care roles not explicitly defined among parents, specialists, FCPs, and others
- Practices lack processes for change or improvement
- Reimbursement is inadequate and linked to well child care and acute care of healthy children
- Consumer involvement is limited or non-existent
Changing a pediatric practice is like trying to change the tire on a bicycle while you are riding it.
MODEL OF IMPROVEMENT
- Learning collaboratives
- PDSA cycles
- Sharing of data
- Quality coach
- Payment linked to proving quality

A MEDICAL HOME SHOULD BE ABLE TO...
- Form active partnerships with families
- Identify and monitor CSHCN's
- Coordinate care in a systematic manner
- Communicate with other community resources and pediatric specialty services
- Provide transitional services for CSHCN's

This requires redesign of existing services

REFERENCES
- Medical Home for the U of W
  - Medicalhome.org
- AAP Medical Home site
  - Medicalhomeinfo.org
- Medical Home Tool Box
- CMHI – Medical Home Index
  - http://medicalhomeimprovement.org
- NCQA
  - NCQA.org
  - Patient-centered medical home (PPC-PCMH)