Providing Quality Care through Medical Homes

National Conference of State Legislatures

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July 26, 2010
Overview

- History of Medical Home
- Definition of a Medical Home
- National Medical Home Initiatives
- Health Care Reform and Medical Home Opportunities
- American Academy of Pediatrics Medical Home Initiatives
History of Medical Home

- Cal Sia, MD, FAAP
- American Academy of Pediatrics, Family Voices and Maternal and Child Health Bureau
- Initial Priority Focus: Children and Youth with Special Health Care Needs
Defining Medical Home

- Primary care
- Family-centered partnership
- Community-based, interdisciplinary, team approach to care
- Preventive, acute and chronic care
- Quality improvement
Medical Home Care Is....

- Accessible
- Family-centered
- Coordinated
- Compassionate
- Continuous
- Culturally-effective
The PCMH concept advocates enhanced access to comprehensive, coordinated, evidence-based, interdisciplinary care

<table>
<thead>
<tr>
<th>Today’s Care</th>
<th>Medical Home Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>My patients are those who make appointments to see me</td>
<td>Our patients are those who are registered in our medical home</td>
</tr>
<tr>
<td>Care is determined by today’s problem and time available today</td>
<td>Care is determined by a proactive plan to meet health needs, with or without visits</td>
</tr>
<tr>
<td>Care varies by scheduled time and memory or skill of the doctor</td>
<td>Care is standardized according to evidence-based guidelines</td>
</tr>
<tr>
<td>I know I deliver high quality care because I’m well trained</td>
<td>We measure our quality and make rapid changes to improve it</td>
</tr>
<tr>
<td>Patients are responsible for coordinating their own care</td>
<td>A prepared team of professionals coordinates all patients’ care</td>
</tr>
<tr>
<td>It’s up to the patient to tell us what happened to them</td>
<td>We track tests and consultations, and follow-up after ED and hospital</td>
</tr>
<tr>
<td>Clinic operations center on meeting the doctor’s needs</td>
<td>An interdisciplinary team works at the top of our licenses to serve patients</td>
</tr>
</tbody>
</table>

Source: Adapted with permission by IBM from Daniel F. Duffy, M.D.
Medical Homes: Integrated Health System

- Patients and Families
- Primary care physicians
- Interdisciplinary health clinicians
- Specialists and subspecialists
- Hospitals and Healthcare Facilities
- Public Health
- Community
State Medical Home Advisory Committee

- Families
- Providers (primary care and subspecialists)
- Interdisciplinary health care clinicians
- Agencies
- Public health
- Hospitals
- Payers
- Businesses
- Faith based groups
What we know about medical home care...
What We Know About Medical Home Care...

- Family satisfaction increases
- Provider satisfaction increases
- Reduced emergency department use
- Reduced hospital days
- Reduced redundancy
- Reduced cost of care per child
- Increase in immunization rates and preventive care visits
What We Know about Medical Home Care...

- **Geisinger Health System**
  - 14 % Reduction in total hospital admissions
  - 9 % Reduction in total medical costs in 24 months
  - Estimated $3.7 million net savings

- **Johns Hopkins Guided Care PCMH* Model**
  - 24 % Reduction in total hospital days
  - 15 % Fewer emergency department visits

*Patient-Centered Medical Home*
What We Know About Medical Home Care...

- **Community Care of NC**
  - 40% decrease in hospitalizations for asthma
  - 16% lower emergency department visit rate
  - $400 million in cost savings for the “aged, blind and disabled population”
The Outcomes of Implementing Patient-Centered Medical Home Interventions: A Review of the Evidence on Quality, Access and Costs from Recent Prospective Evaluation Studies, August 2009

Prepared by
Kevin Grumbach, MD, Thomas Bodenheimer, MD MPH
and Paul Grundy MD, MPH

Abundant research comparing nations, states and regions within the U.S., and specific systems of care has shown that health systems built on a solid foundation of primary care deliver more effective, efficient, and equitable care than systems that fail to invest adequately in primary care. However, some policy analysts have questioned whether these largely cross-sectional, observational studies are adequate for making inferences about whether implementing major policy interventions to strengthen primary care as part of health reform would in the relatively short term “bend the cost curve” at the same time as improving quality of care and patient outcomes.

Is there research using prospective, controlled study designs which shows what happens to quality, access and costs as a result of investments to enhance and improve primary care? Have recent evaluations documented the outcomes of interventions in the U.S. promoting primary care patient-centered medical homes (PCMHs)?

The answer to these questions is, Yes. Although some major evaluations of the PCMH are only now getting off the ground, including the evaluation of the Medicare Medical Home Demonstrations, evaluations of other primary care initiatives are much farther along, and the findings of some of these evaluations are starting to emerge in peer-reviewed journals and other publications.

This briefing document summarizes key findings from recent PCMH evaluator studies. These studies have investigated a variety of PCMH models, in a variety of settings ranging from integrated delivery systems to community-based office practices. Some evaluations examine interventions focused on general primary care patient populations, and others on high risk subsets. The evaluations span privately insured patients, Medicaid, SCHIP and Medicare beneficiaries, and the uninsured.

Across these diverse settings and patient populations, evaluation findings consistently indicate that investments to redesign the delivery of care around a primary care PCMH yield an excellent return on investment:
- Quality of care, patient experiences, care coordination, and access are demonstrably better.
- Investments to strengthen primary care result within a relatively short time in reductions in emergency department visits and inpatient hospitalizations that produce savings in total costs. These savings or a minimum offset the new investments in primary care in a cost-neutral manner, and in many cases appear to produce a reduction in total costs per patient.

This summary provides a review of recent PCMH evaluations. The initial section of the summary provides a concise view of the key data on cost outcomes. The subsequent section provides more information about each PCMH model and includes data on quality and access in addition to costs, as well as reference citations.
Medical Home Payment Model

“Hybrid” Funding:

- Fee for service
- Per member per month
- Infrastructure
National Medical Home Initiatives
Fixing Health Care

Most hospitals are designed for the nineteenth century. Most doctors don’t know how to share power. Most patients with complicated problems don’t receive coordinated care. It’s time for a revolution – led from within.
The United States spends more on health care per capita – by far – than any of the other OECD* countries…yet it ranks at the bottom 25% of those countries on life expectancy.

*Organization for Economic Co-operation and Development
Joint Principles of the Patient-Centered Medical Home

- American Academy of Pediatrics
- American Academy of Family Physicians
- American College of Physicians
- American Osteopathic Association

March 2007
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

www.medicalhomeinfo.org
www.pcpcc.net
Medical Home Joint Principles: Pediatric Preamble

- Family-centered care
- Community-based system of care
- Transitions
- Value
National and State Medical Home Activities

- Federal Agencies: MCHB, CDC, SAMHSA
- CMS: Medicare, Medicaid and CHIP Advocacy
- National Academy for State Health Policy
- Council of State Governments
- Legislation: Federal and State
- National Conference of State Legislatures
The Patient-Centered Primary Care Collaborative (PCPCC)

- Coalition of over **750**:  
  - Major employers  
  - Consumer groups  
  - Primary care physicians  
  - Health plans  
  - Advocates  
  - Others

- **Mission**: To advance the patient-centered medical home
Examples of Broad Stakeholder Support & Participation

**Providers**
- 333,000 primary care providers
- ACP
- AAFP
- AOA
- ABIM
- ACC
- ACOI
- AMA

**Purchasers**
- Most of the Fortune 500
- FedEx
- IBM
- Dow
- General Electric
- Microsoft
- Merck & Co.
- Business Coalitions

**Patients**
- 80 Million lives
- AARP
- AFL-CIO
- National Consumers League
- SEIU
- Foundation for Informed Decision Making

**Payers**
- BCBSA
- United
- CIGNA
- WellPoint

**The Patient-Centered Medical Home**
- Aetna
- Humana
- Kaiser Permanente
- Geisinger

www.pcpcc.net
Patient-Centered Medical Home

2009 Overview of Pilot Activity and Planning Discussions

- Multi-Payer pilot discussions/activity
- Identified pilot activity
- No identified pilot activity – 6 States

Map showing states with and without identified pilot activity.
Blue Cross Blue Shield Plan Pilots
(As of March 2010)

Pilots in planning phase for 2010 implementation
Multi-Stakeholder demonstration
Pilot activity in early stages of development
There are 37 States Working to Advance Medical Homes for Medicaid or CHIP Beneficiaries

SOURCE: NASHP analysis
Medical Home Measurement and Evaluation
MCHB Core Outcome #2: CSHCN who receive coordinated, ongoing comprehensive care within a medical home


Nationwide
47.1% of CSHCN met outcome

State Ranking
Higher=Better performance
- Green: Significantly higher than U.S.
- Darker Green: Higher than U.S. but not significant
- Lighter Green: Lower than U.S. but not significant
- Lighter Yellow: Significantly lower than U.S.

Statistical significance: p<.05
Medical Home Measurement and Evaluation

- Center for Medical Home Improvement Medical Home Index
- NCQA* Physician Practice Connections® Patient Centered Medical Home™ (PPC®-PCMH™) Recognition Program
- Recently released monograph: *Measuring Medical Homes*
- Pilots/Demonstration Projects
- Outcomes

*National Committee for Quality Assurance
Medical Home Index: Pediatric

- Measuring the Organization and Delivery of Pediatric Primary Care for All Children, Youth and Families
- Available from – Center for Medical Home Improvement

www.medicalhomeimprovement.org
Health Care Reform and Medical Home
The Affordable Care Act will:

- Create Medicaid medical home demonstration projects for people with chronic conditions
  - Payment: tiered to reflect the severity/number of chronic conditions
  - Not limited to per-member per-month (PMPM)
  - Chronic conditions include: a mental health condition, a substance use disorder, asthma, diabetes, heart disease and obesity
The Affordable Care Act will:

- Provide grants to establish community-based health teams to support primary care providers
  - Payment: tiered to reflect the severity/number of chronic conditions;
  - Provides PMPM payments to providers, separate payment to health teams
Health Reform and Medical Home

The Affordable Care Act will:

- Establish a voluntary pediatric State Accountable Care Organization (ACO) demonstration
  - Allows pediatricians that meet specialized requirements to be recognized as an ACO for purposes of receiving incentive payments
  - Performance guidelines; if lower cost, share savings
  - Secretary of HHS must work with pediatric providers to establish guidelines
Medical Home “Definition” in the Affordable Care Act

- Personal physician
- Whole person orientation
- Coordinated and integrated care
- Safe and high quality care
  - Evidence-informed medicine
  - Appropriate use of health information technology
  - Continuous quality improvement
- Expanded access to care
- Payment that recognizes added value of primary care components
American Academy of Pediatrics
Medical Home Initiatives
Cooperative agreement between the Maternal and Child Health Bureau/HRSA and the AAP

Medical Home Toolkit

Interdisciplinary Medical Home Competencies (LEND Program)

Resident Initiative

Educational Maintenance of Certification Courses

New Web site: www.medicalhomeinfo.org
The Medical Home is the model for 21st century primary care, with the goal of addressing and integrating high quality health promotion, acute care and chronic condition management in a planned, coordinated and family-centered manner.

How can this Toolkit help your practice?

The Toolkit supports your development and/or improvement of a pediatric Medical Home. It also prepares you to apply for and potentially meet the National Committee for Quality Assurance (NCQA) Physician Practice Connections® Patient Centered Medical Home (PPC-PCMH®) Recognition program requirements. The AAP created a crosswalk between each of the Toolkit building blocks and the NCQA PPC-PCMH Recognition Program 'must pass' elements.

Why it is important to measure Medical Home at your practice?

Patient care associated with the Medical Home improves outcomes, such as health status, timeliness of care, family centeredness and family functioning. The NCQA PPC-PCMH standards provide a way to qualify and quantify care in the Medical Home. In some practices, scoring at NCQA higher levels has resulted in enhanced payment to the practice.

Doctors Lail and Tayloe improved their practice and patient outcomes by implementing the Medical Home approach.

How to Begin

The Toolkit is organized into six building blocks that provide guidance for Medical Home implementation with links to downloadable tools.
Additional Academy Initiatives and Resources
Medical Home Initiatives & Resources by State

Select a state for more specific resource information pertinent to your community.
Submission of new state resources or corrections may be emailed to: medical_home@aap.org

STATE PAGES

U.S. MAP
- Alabama
- Alaska
- Arizona
- Arkansas
- California
- Colorado
- Connecticut
- Delaware
- Florida
- Georgia
- Hawaii
- Idaho
- Illinois
- Indiana
- Iowa
- Kansas
- Kentucky
- Louisiana
- Maine
- Maryland
- Massachusetts
- Michigan
- Minnesota
- Mississippi
**State Page Example - Illinois**

**ILLINOIS MEDICAL HOME INFO**

- Medical Home Contact
- Announcements
- Projects and Grant Initiatives
- Partners in State
- Public Policy/Legislation
- State Medical Home Data
- Other Resources

**State Medical Home Contact**

Rita Klemm, MSW, DSCC Technical Assistance Unit, Medical Home Project Coordinator, Div of Specialized Care for Children, Univ of Illinois at Chicago

Address: 3135 Old Jacksonville Road, Springfield, IL 62704-6488

Phone: 217/558-2340 | Fax: 217/558-0773 | Email: rkklemm@uic.edu

Gerri Clark, RN, MSN, Interim Director, Div of Specialized Care for Children, Univ of Illinois at Chicago

Address: 3135 Old Jacksonville Road, Springfield, IL 62704-6488

Phone: 217/558-2340 | Fax: 217/558-0773 | Email: geclark@uic.edu

**STATE PAGES**

- U.S. MAP
  - Alabama
  - Alaska
  - Arizona
  - Arkansas
  - California
  - Colorado
  - Connecticut
  - Delaware
  - Florida
  - Georgia
  - Hawaii
  - Idaho
  - Illinois
  - Indiana
  - Iowa
  - Kansas
Medical Home Data Portal

- Presents state-by-state summaries and across-state comparisons on children’s medical home using standardized data
- Get one page at-a-glance profiles on how many children in your state meet overall criteria for having a medical home and topic-by-topic specific findings
- Compare your state to other states and the nation on the percentage of children who receive care within a medical home

www.medicalhomedata.org
## Medical Home Performance Profile for ALL CHILDREN

Data Source: 2007 National Survey of Children’s Health

### Prevalence of Medical Home in Colorado

<table>
<thead>
<tr>
<th>All Children (age 0-17)</th>
<th>State</th>
<th>HRSA Region VIII</th>
<th>Nation</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Medical Home Criteria</td>
<td>59.3%</td>
<td>61.1%</td>
<td>57.5%</td>
</tr>
</tbody>
</table>

### Age of Child

<table>
<thead>
<tr>
<th>Age</th>
<th>State</th>
<th>HRSA Region VIII</th>
<th>Nation</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 - 5 years old</td>
<td>64.7%</td>
<td>67.0%</td>
<td>64.0%</td>
</tr>
<tr>
<td>6 - 11 years old</td>
<td>59.8%</td>
<td>60.2%</td>
<td>55.2%</td>
</tr>
<tr>
<td>12 - 17 years old</td>
<td>53.2%</td>
<td>55.8%</td>
<td>53.4%</td>
</tr>
</tbody>
</table>

### Sex of Child

<table>
<thead>
<tr>
<th>Sex</th>
<th>State</th>
<th>HRSA Region VIII</th>
<th>Nation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>56.0%</td>
<td>59.7%</td>
<td>56.8%</td>
</tr>
<tr>
<td>Female</td>
<td>62.9%</td>
<td>62.8%</td>
<td>58.2%</td>
</tr>
</tbody>
</table>

### Household Poverty Level (Federal Poverty Level [FPL] Guidelines)*

<table>
<thead>
<tr>
<th>Poverty Level</th>
<th>State</th>
<th>HRSA Region VIII</th>
<th>Nation</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 - 99% FPL</td>
<td>37.1%</td>
<td>37.7%</td>
<td>39.4%</td>
</tr>
<tr>
<td>100 - 199% FPL</td>
<td>54.9%</td>
<td>58.1%</td>
<td>49.4%</td>
</tr>
<tr>
<td>200 - 399% FPL</td>
<td>61.0%</td>
<td>65.2%</td>
<td>62.5%</td>
</tr>
<tr>
<td>400% FPL or higher</td>
<td>69.8%</td>
<td>70.2%</td>
<td>63.3%</td>
</tr>
</tbody>
</table>

*For more information on FPL guidelines please visit: [http://aspe.hhs.gov/poverty/07PovertyS.html](http://aspe.hhs.gov/poverty/07PovertyS.html)

### Race/Ethnicity of Child

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>State</th>
<th>HRSA Region VIII</th>
<th>Nation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hispanic</td>
<td>46.6%</td>
<td>41.8%</td>
<td>38.5%</td>
</tr>
<tr>
<td>White, Non-Hispanic</td>
<td>66.2%</td>
<td>67.5%</td>
<td>68.0%</td>
</tr>
<tr>
<td>Black, Non-Hispanic</td>
<td>NA**</td>
<td>41.4%</td>
<td>44.2%</td>
</tr>
<tr>
<td>Multi-Racial/Other, Non-Hispanic</td>
<td>58.3%</td>
<td>52.9%</td>
<td>55.6%</td>
</tr>
</tbody>
</table>

### Type of Insurance

<table>
<thead>
<tr>
<th>Type of Insurance</th>
<th>State</th>
<th>HRSA Region VIII</th>
<th>Nation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public insurance such as Medicaid or SCHIP</td>
<td>40.6%</td>
<td>47.6%</td>
<td>45.4%</td>
</tr>
<tr>
<td>Private health insurance</td>
<td>63.0%</td>
<td>68.3%</td>
<td>66.5%</td>
</tr>
</tbody>
</table>

### Components of Medical Home

#### Accessibility

<table>
<thead>
<tr>
<th>Component</th>
<th>State</th>
<th>HRSA Region VIII</th>
<th>Nation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Has a personal doctor or nurse</td>
<td>90.6%</td>
<td>90.9%</td>
<td>92.2%</td>
</tr>
</tbody>
</table>

#### Family-Centered Care (% who report "usually" or "always")

<table>
<thead>
<tr>
<th>Component</th>
<th>State</th>
<th>HRSA Region VIII</th>
<th>Nation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctor spends enough time</td>
<td>81.5%</td>
<td>82.3%</td>
<td>79.3%</td>
</tr>
<tr>
<td>Doctor listens carefully</td>
<td>90.7%</td>
<td>90.9%</td>
<td>89.4%</td>
</tr>
<tr>
<td>Doctor provides specific needed information</td>
<td>87.1%</td>
<td>86.9%</td>
<td>84.8%</td>
</tr>
<tr>
<td>Doctor helps parent feel like partner in care</td>
<td>89.2%</td>
<td>89.7%</td>
<td>87.6%</td>
</tr>
</tbody>
</table>

#### Comprehensive

<table>
<thead>
<tr>
<th>Component</th>
<th>State</th>
<th>HRSA Region VIII</th>
<th>Nation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Has a problem getting referrals when needed</td>
<td>28.5%</td>
<td>20.7%</td>
<td>17.7%</td>
</tr>
<tr>
<td>Has a usual source for both sick and well care</td>
<td>92.2%</td>
<td>93.8%</td>
<td>93.1%</td>
</tr>
</tbody>
</table>

#### Coordinated (% among children receiving 2 or more types of services)

<table>
<thead>
<tr>
<th>Component</th>
<th>State</th>
<th>HRSA Region VIII</th>
<th>Nation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Received any help arranging or coordinating care</td>
<td>17.5%</td>
<td>17.9%</td>
<td>20.7%</td>
</tr>
<tr>
<td>Reported getting all help needed arranging care for child</td>
<td>65.9%</td>
<td>67.0%</td>
<td>68.7%</td>
</tr>
<tr>
<td>Very satisfied with communication between doctors, when needed</td>
<td>70.4%</td>
<td>69.4%</td>
<td>72.3%</td>
</tr>
<tr>
<td>Very satisfied with communication between doctors and school, when needed</td>
<td>65.7%</td>
<td>64.5%</td>
<td>62.3%</td>
</tr>
</tbody>
</table>

#### Culturally Effective (% who report "usually" or "always")

<table>
<thead>
<tr>
<th>Component</th>
<th>State</th>
<th>HRSA Region VIII</th>
<th>Nation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctor is sensitive to family customs and values</td>
<td>90.7%</td>
<td>91.9%</td>
<td>89.2%</td>
</tr>
<tr>
<td>Availability of interpreter, when needed</td>
<td>NA**</td>
<td>57.3%</td>
<td>64.2%</td>
</tr>
</tbody>
</table>

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Implementing the Medical Home in Medicaid, CHIP, and Multistakeholder Demonstration Programs

Introduction
The medical home is quickly spreading throughout the health care system as an innovative model for delivering high-quality, culturally effective, integrated care that has the potential to lower costs and improve quality and patient satisfaction. Recent reports of state Medicaid, Children’s Health Insurance Program (CHIP), and multistakeholder demonstration activity indicate that most states are now either implementing or planning to implement some form of medical home project in state Medicaid, CHIP, or other programs. Many, but not all, of these medical home projects involve pediatrics.

In addition, current health care reform efforts at the federal level include significant new funding for Medicaid medical home demonstration programs. Should these provisions be included AAAP chapter representatives do not need to know everything about the medical home to become involved at the state level. The AAP has many resources - including this document - to assist you.

This Issue Brief serves to provide guidance to AAP chapters working with states to implement medical home projects in Medicaid and CHIP as well as multipayer demonstration programs, either through legislation or through administrative changes. It also addresses a number of the policy questions that frequently arise in creating state supports for the medical home. AAP chapters with questions should not hesitate to contact the AAP Division of State Government Affairs for additional information or consultation, at 800/433-9016, ext 7799 or stgov@aap.org.

AAP Division of State Government Affairs
800/433-9016 ext 7799 or stgov@aap.org
Medical Home and Health Information Technology (HIT)

- Supports development of patient registries
- Informs physicians of overdue and abnormal tests
- Allows clinical data to be maintained in a database
- Organizes information in searchable data fields supports case and population management
- Computerized alerts to support evidence-based medicine
- Interactive Web sites, secure messaging and personal health records to support communication between physician and parent/family
Medical Student Education

- Effort recently initiated by Patient Centered Primary Care Collaborative
- Represents American Academy of Family Physicians, American Academy of Pediatrics, American Osteopathic Association, American College of Physicians collaboration
- Goal to develop principles to guide education at the medical school level related to medical home
State Challenges and Opportunities

- Definition of Medical Home
- “Consumer” knowledge and involvement
- Evaluation of Pilot/Demonstration Programs
- HIT
- Certification vs Recognition
- Training and education
- Measurement and Performance Standards
- Payment
- Subspecialty involvement/co-management
- Health care reform implementation
...and it is the kind of quality health care that we all want, need and deserve for ourselves and our families.
Thank you!

- AAP National Center for Medical Home Implementation--Technical Assistance
  800/433-9016, ext 4311
  smontasir@aap.org

- AAP State Government Affairs
  800/433-9016, ext 7799
  stgov@aap.org