What is Medical Home and Why Does Connecticut Need This Model?

HealthFirst Authority
Quality, Access, and Safety Workgroup

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April, 2008

Definition of Medical Home

- Care that is:
  - Accessible
  - Family-centered
  - Comprehensive
  - Continuous
  - Coordinated
  - Compassionate
  - Culturally-effective

Definition of Medical Home

- And for which the primary care provider shares responsibility with the family.

AAP/ AAFP/ NAPNAP/ ACP/ AOA

Joint Principles of the PCMH
AAP, AAFP, ACP, AOA
March 2007

- **Whole person orientation**
- **Personal physician**
- **Physician directed medical practice**
- **Care is coordinated and/or integrated**
- **Quality and safety**
- **Enhanced access to care**
- **Payment to support the PC-MH**

Patient-Centered Medical Home Joint Principles Statement

- Major Focus of Advocacy for All Primary Care Specialties
- Personal physician/ relationship
- Quality
- Access
- Equity
- Financing

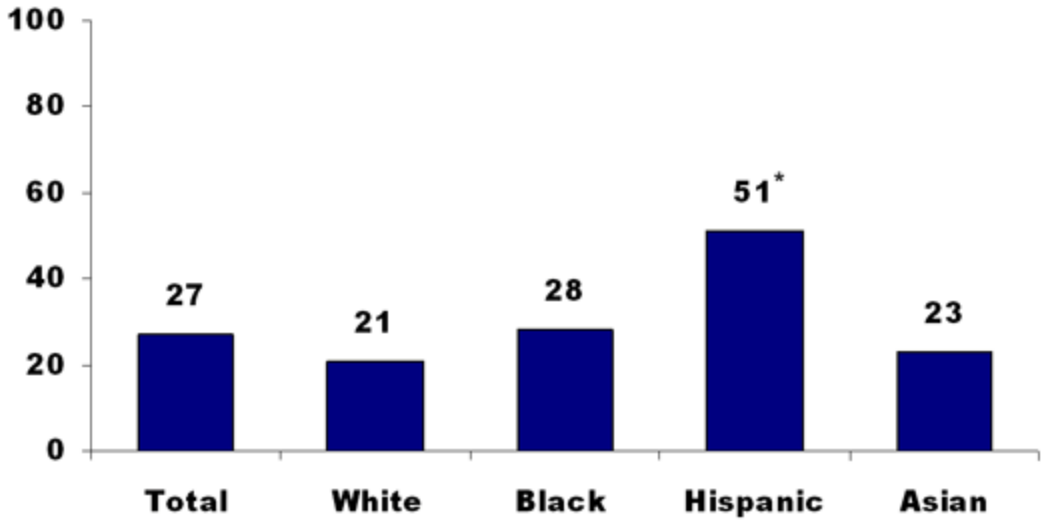
Issues

- Can Primary Care Survive?
  - Capacity of current workforce
  - Attracting new providers to workforce
- Why Do We Need Medical Home?
  - Highest quality with least disparity to access occurs when Medical Home available

What About Disparity?

Almost 2.5 times as many Hispanics as whites report having no doctor.

Percentage of adults ages 18 to 64 reporting no regular doctor, 2006



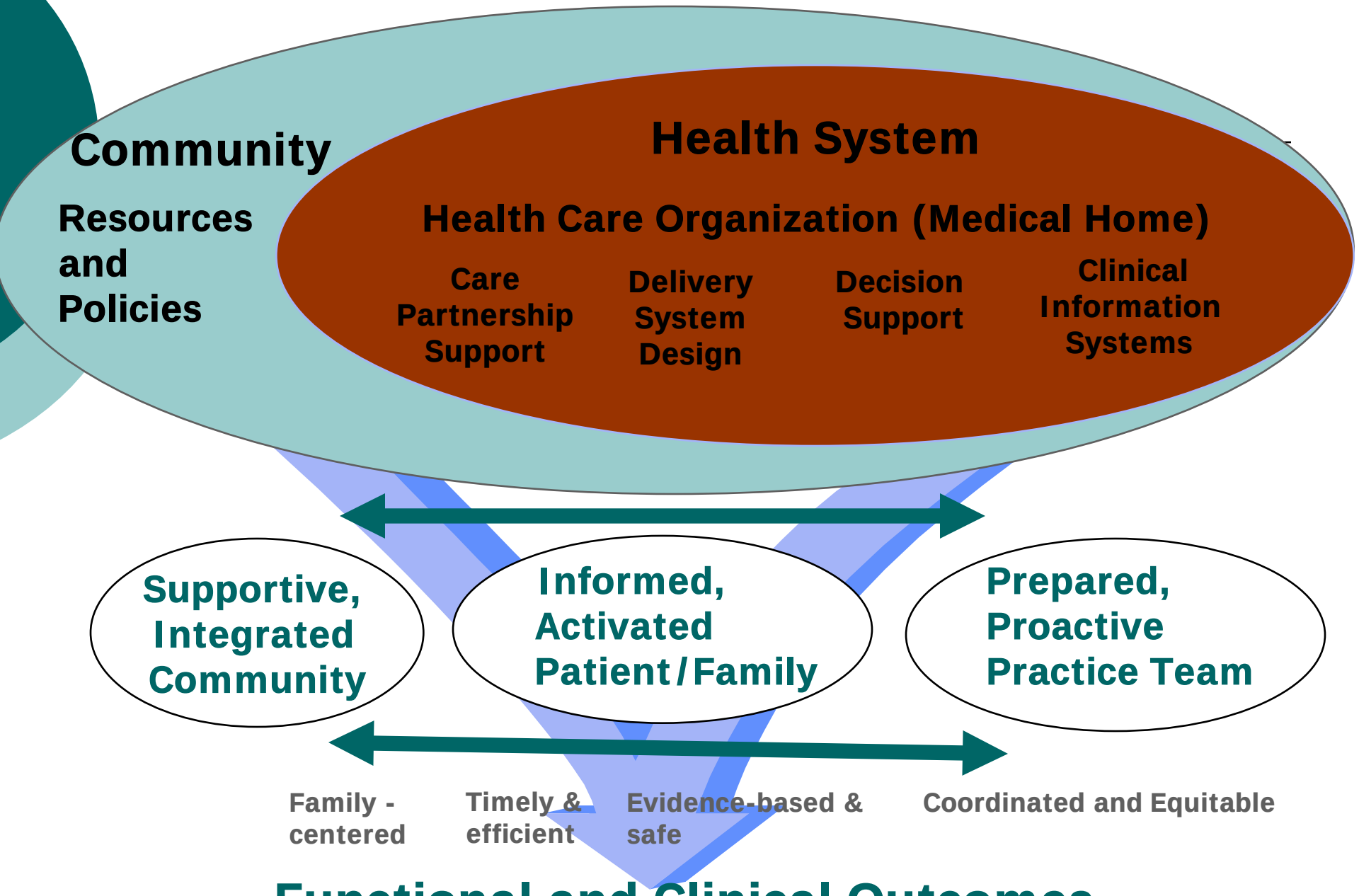
* Compared with whites, differences remain statistically significant after adjusting for age, income, and insurance.
Source: The Commonwealth Fund. Health Care Quality Survey. 2006.

Trying Hard Is Not Enough

Is Medical Home Enough?

- Medical Home demands system re-design:
  - Financing
  - Quality measurement
  - Regulatory support
  - State and Federal policy support

Chronic Care Model (Wagner, et al)



What is Care Coordination?

A process that facilitates the linkage of children and their families with appropriate services and resources in a coordinated effort to achieve good health.

AAP 2005

Care Coordination- ACP

- Ensuring communication among specialists and PCP and families
- Tracking if referrals happen
- System to prevent errors among multiple providers
- Tracking Test Results

What Is Case Management?

- Began in era of managed care as mechanism of ensuring access to appropriate benefits package of services: utilization review approach.
- Any effective, sustainable community-based Medical Home system must support linkages between practice-based CC and community-based CM!

What Constitutes CC in a Pediatric Medical Home, and What Does It Cost?

National Study of Care Coordination Measurement in Medical Homes

Antonelli and Antonelli, 2004

Focus of Encounter – Aggregate Data –

Primary Focus	% Encounters
Clinical / Medical Management	67%
Referral Management	13%
Social Services (ie. Housing, food, clothing…)	7%
Educational / School	4%
Developmental / Behavioral	3%
Mental Health	3%
Growth / Nutrition	2%
Legal / Judicial	1%

Outcome Prevented – Aggregate Data Antonelli and Antonelli, 2004

The CCMT allows only one outcome prevented per encounter.
32% of total 3855 CC encounters prevented something.

Of the 1232 CC Encounters where prevention was noted as an outcome:

Outcome Prevented	# CC Encounters	Percentage
Visit to Pediatric Office / Clinic	714	58%
Emergency Department Visit	323	26%
Subspecialist Visit	124	10%
Hospitalization	47	4%
Lab / X-Ray	16	1%
Specialized Therapies	8	1%

62% of RN CC Encounters prevented something.
33% of MD CC Encounters prevented something.

RNs are responsible for coding 81% of the Emergency Department preventions and 63% of the sick office visit preventions.

Implications for Policy and Practice

- With the advent of Patient-Centered Medical Home, all primary care provider organizations are focusing on CC as critical function
- Payers and purchasers are looking at P4P to incentivize CC
- CC for adult chronic condition CC is very different from pediatric CC

Implications for Policy and Practice

- Disease-specific CC (aka, chronic condition management/ CCM) should be quite implementable
- However, pediatric CC is not identical to adult CC
- Mechanisms of operationalizing and measuring CC functionality at MH practice level are being developed and tested in CT and across US
- CC as a discipline must be developed in order to achieve high performing health care system

Gathering Supports for Meaningful System Change for CC

- The Commonwealth Fund project to develop care coordination (CC) as an integral component of pediatric primary care
- Family-based care coordination measurement study
- Multi-site study of CC in clinical settings supporting transition for YSHCN

Measuring CC as a Practice-Based Function

- CC can be integrated into on-going QI activities within a practice, or a network
- Outcomes of effective CC provision can be benchmarked and linked to “pay for performance”: as long as resources are provided to support CC as a dedicated function

What Can Be Measured re: CC?

- Adult Medical Home
  - Screening rates for disease and risk factors
  - Screening for secondary disabilities
  - Presence of registry and its utilization
  - Development of Care Plans (these have CPT codes already)
  - Mechanism for linkage from practice-based CC to community-based CM
  - Training opportunities for CC'ers
  - ED and in-patient utilization for patients with chronic conditions

What Can Be Measured re: CC?

- Pediatric Medical Home
  - Parent/ youth partners in QI at practice level
  - Developmental and behavioral screening
  - Screening for secondary disabilities (much less prevalent than adult practice)
  - Presence of registry and its utilization
  - Development and deployment of Care Plans (these have CPT codes already)
  - Mechanism for linkage from practice-based CC to community-based CM
  - Training opportunities for CC'ers
  - ED and in-patient utilization for patients with chronic conditions

Stakeholders

- Families
- Employers (Leapfrog Group, National Quality Forum)
- Providers
- Community-Based Organizations
- Payers: Medicaid and Commercial (PCPCC)
- State and Federal Agencies
- Legislators

PCMH-PPC: NCQA, AAFP, ACP, AAP and AOA
Medical Home Qualifying Criteria

Linked to Reimbursement

NCQA

Standard 1: Access and Communication	Pts
Has written standards for patient access and patient communication**	4
Uses data to show it meets its standards for patient access and communication**	5
	9

Standard 2: Patient Tracking and Registry Functions	Pts
Uses data system for basic patient information (mostly non-clinical data)	2
Has clinical data system with clinical data in searchable data fields	3
Uses the clinical data system	3
Uses paper or electronic-based charting tools to organize clinical information**	6
E. Uses data to identify important diagnoses and conditions in practice**	4
F. **Generates lists of patients and reminds patients and clinicians of services needed (population management)**	3
	21

Standard 3: Care Management	Pts
A. Adopts and implements evidence-based guidelines for three conditions **	3
B. **Generates reminders about preventive services for clinicians**	4
C. **Uses non-physician staff to manage patient care**	3
D. **Conducts care management, including care plans, assessing progress, addressing barriers**	5
E. Coordinates care//follow-up for patients who receive care in inpatient and outpatient facilities	5
	20

Standard 4: Patient Self-Management Support	Pts
A. **Assesses language preference and other communication barriers**	2
B. Actively supports patient self-management**	4
	6

Standard 5: Electronic Prescribing	Pts
A. **Uses electronic system to write prescriptions**	3
B. **Has electronic prescription writer with safety checks**	3
C. **Has electronic prescription writer with cost checks**	2
	8

Standard 6: Test Tracking	Pts
A. Tracks tests and identifies abnormal results systematically**	7
B. **Uses electronic systems to order and retrieve tests and flag duplicate tests**	6
	13

Standard 7: Referral Tracking	PT
A. Tracks referrals using paper-based or electronic system**	4
	4

Standard 8: Performance Reporting and Improvement	Pts
A. Measures clinical and/or service performance by physician or across the practice**	3
B. **Survey of patients' care experience**	3
C. Reports performance across the practice or by physician **	3
D. **Sets goals and takes action to improve performance**	3
E. **Produces reports using standardized measures**	2 1
F. **Transmits reports with standardized measures electronically to external entities**	15

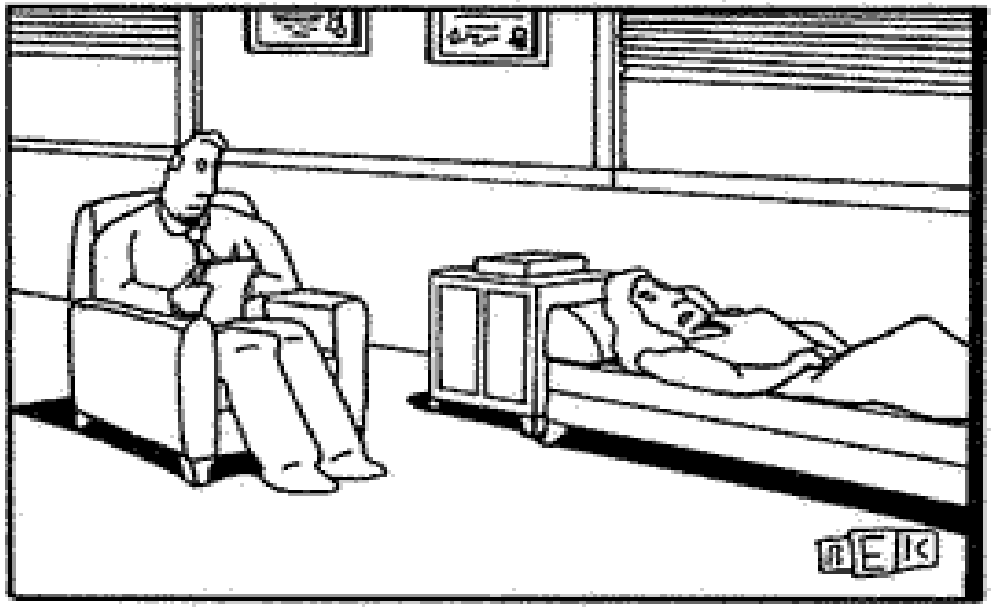
Standard 9: Advanced Electronic Communications	Pts
A. **Availability of Interactive Website**	1
B. **Electronic Patient Identification**	2
C. **Electronic Care Management Support**	1
	4

National Noteworthy Models of Medical Home and Care Coordination

- Minnesota Medicaid Transformation
- North Carolina
- PACE: case management/ CC for adults with chronic conditions

Recommendations for System Re-Design

- Results Based Accountability
- Healthcare systems need QI infrastructure and supports
- CT-CHIP means of providing that infrastructure for pediatric healthcare
- Build capacity in Primary Care
- Build capacity in Subspecialty Care
  - Co-management in Medical Home
- System to support CC
- EHR
- Align incentives with goals



"Well, I do have this recurring dream that one day I might see some results."

Useful Websites

- http://www.medicalhomeinfo.org: American Academy of Pediatrics hosted site that provides many useful tools and resources for families and providers
- http://www.medicalhomeimprovement.org: tools for assessing and improving quality of care delivery, including the Medical Home Index, and Medical Home Family Index
- www.abimfoundation.org: excellent review of state of CC in adult medicine

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