



Medical Home Principles, Findings & Pilots

Commonwealth North Health Care Action Coalition
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Eric Britten
Britten & Associates, LLC
P.O. Box 240665, Anchorage, AK 99524-0665
Tel. 907-440-8181 www.BrittenAssociates.com



Today's Presentation

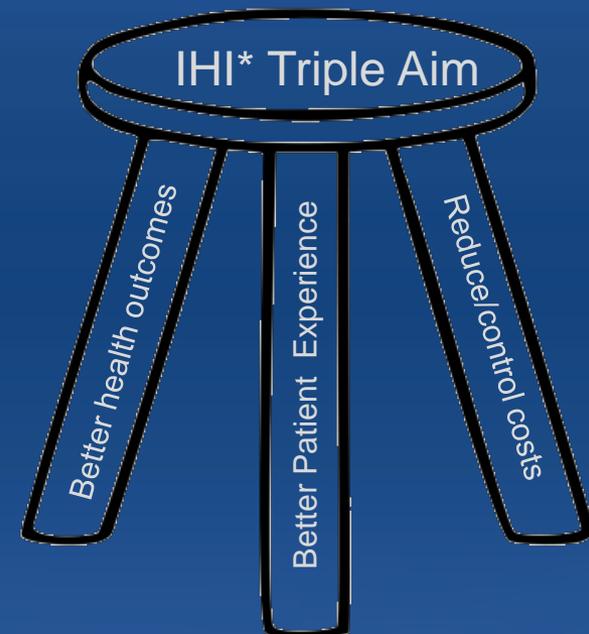
- **Medical home overview** (Eric Britten)
 - The principles of medical homes
 - Medical home benefits
 - Medical home pilot projects and outcomes
 - Alaska and medical homes
- **APCA focus on the PCHCH** (Marilyn Kasmar)
- **Juneau update on the medical home**
(Shelley Hughes)



What Is A Medical Home?

The medical home is an approach to providing comprehensive primary care that:

- Increases the quality of health of the population
- Enhances patient's health care experience
- Reduces, or at least controls, the per capita cost of health care



*Institute for Healthcare Improvement



What Is A Medical Home?

- Also known as
 - PCMH (Patient Centered Medical Home)
 - PCHCH (Patient Centered Health Care Home)
 - PCPCH (Patient Centered Primary Care Home)
 - Medical Home
 - Primary Care Home
- Associated with
 - Patient centered care



Medical Home Origin

- The American Academy of Pediatrics (AAP) formally introduced the medical home concept in 1967.
- Children with disabilities or chronic conditions
- Evolution

"To infinity and beyond!"





Principles of a Medical Home

- **Patient centered:** puts the patient at the center of their health care decisions
- **Access to care:** makes it easier for patients to get care and advice when they need it
- **Comprehensive care:** provides the right care at the right time and eliminates unnecessary procedures
- **Coordinated and integrated care:** coordinates care across multiple providers and services



Principles of a Medical Home

- **Quality and safety:** Continuous quality improvement, clinical support tools, evidence based medicine
- **Continuity of care:** partners patients with their own team of primary care providers
- **Alternate reimbursement model**
 - Existing visit-based fee for face-to-face services
 - A bundled per-member-per-month (PMPM) component that covers medical home services not currently reimbursed by most payers
 - A performance based component reflective of the achievement of defined quality and efficiency goals



Benefits of a Medical Home

- Reductions in emergency room visits
- Reductions in hospital admissions
- Reductions in length of hospital stays
- Reductions in total medical and pharmacy costs
- Reduced diagnostic imaging expense
- Comprehensive evaluation and management for chronic disease management patients
- Improved quality outcomes: improves health outcomes
- Improved patient satisfaction
- Improved provider & team satisfaction
- Recruitment incentive





What's *REALLY* Different

- The focus is on wellness, not cure
- Care is focused on the whole patient
- The PCP and care team collaborate with the patient
- Care team members focus on the patient, not the PCP
- The patient is at the center of the care team
- Interactions don't just happen at the clinic
- The care team and patient develop a care plan together
- The patient can learn to manage much of their own care
- Populations as well as patients are managed
- Data is used to continuously assess and improve care
- Costs are being reduced or controlled



Patient-Centered Medical Home

Overview of Pilot Activity and Planning Discussions



Source: Patient Centered Primary Care Collaborative (PCPCC)



Medical Home Models

- No single model
- Most pilot projects develop their own models, principles, standards, quality metrics
 - Over 26 pilot projects in 25 states
 - More than 14,000 physicians caring for nearly 5 million patients
 - Length of pilots: 2 – 3 years average
- Recognition programs
 - NCQA
 - Joint Commission



Medical Home Interventions

“Investing in primary care patient centered medical homes results in improved quality of care and patient experiences, and reductions in expensive hospital and emergency department utilization.”

*Outcomes of Implementing Patient Centered Medical Home Interventions,
Patient Centered Primary Care Collaborative (PCPCC), November 2010*



Pilot Project Outcomes

- 16-24% reduction in hospital admissions¹
- 29-39% reduction in ED (emergency room) visits¹
- 10% decrease in diagnostic imaging expenses¹
- \$200-\$600 reduction in costs per patient per year¹
- V.A. saved \$593 per patient per year in a CDM medical home program¹
- Community Care of N.C.: Saved \$974.9M over 6 years¹
- BCBS of Michigan's medical home incentive program saved the payer \$80M in 2010²

¹ Outcomes of Implementing Patient Centered Medical Home Interventions, PCPCC, November 2010

² Blues program rewards doctors for offering enhanced access, cutting costs, Detroit News, January 2011



Alaska Clinics are Transforming

CHCs are Patient-Centered Health Care Homes



What Makes CHCs Ideal "Patient-Centered Health Care Homes"?

- **Patient-Centered:** The patient is engaged and expected to play a central and responsible role working toward better health.
- **Comprehensive Services:** CHCs offer case management, preventive services, education, community outreach, and pharmacy services in addition to regular primary care which includes medical, dental, and behavioral health care
- **Physicians:** CHC providers are mission-oriented, working to improve the health of the patients they serve. They care about their patients and treat

From our Medical Director, Why We Are Transforming to a Medical Home

We are fundamentally changing the way we deliver health care. We are moving **from the current model** where patients are passive recipients of care to **passive patient recipients** supported by a **clinical team** where care is provided by a true team of professionals focusing their collective knowledge, skills, and experience on the collaborative management of patients.

The benefit from superior health outcomes. Our patients will benefit from improved career satisfaction. Our staff will benefit from a supportive learning environment. The nurse, doctor and case manager will be set up as what is called a patient-centered medical home - an approach in which a team of people such as a nurse, doctor and case manager provide comprehensive care for each patient. The case manager, for example, would follow-up with the patient between visits.

Your Medical Home

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 Cost-effective & Quality Dental Care
 Cost-effective & Quality Behavioral Health Care
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- Our Locations
- About Us
- Services
- Surveys
- Links
- Patient Information
- Job Postings

Welcome

Alaska's Medical Home

All our patients see a Medical Doctor at each visit!

Welcome to our website and our interactive website! There is so much to do and learn here. Our goal is to offer a website that is the same quality as the care you receive at our clinics. We trust that you will find what you are looking for.





Alaska Health Care Commission Recommendation

2010-2014 strategic plan

“The Commission recommends that the Governor and Alaska Legislature aggressively pursue development of patient-centric care models through payment reform, removal of statutory and regulatory barriers, and implementation of pilot projects. ”



An Alaska Medical Home Pilot

Alaska has unique rural and frontier clinic issues:

- Remote communities; geographic isolation
- Small populations; low-volume practices
- Extensive use of non-physician providers
- Lack of access to specialty care
- Lack of transportation and communications infrastructure
- Lab and x-ray results
- Lack of pharmacy system
- Health care worker crisis
- Challenges to living a healthy lifestyle

Existing recognition programs don't address these issues



Purpose of a Pilot Project

- Develop a medical home model for a specific target population, geographic area or both
- Test the elements of the medical home model in the environment for which it was developed
 - Identify issues; improve the model
- Measure effects of the model
 - Vs. a control group
- Project the longer term benefits if the model is implemented on a large scale
- Size of pilot must be sufficient to produce statistically reliable data



QUESTIONS

Medical home resources at: www.brittenassociates.com/medicalhome.htm

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