

# Medical Home



- ◆ “The comprehensive and coordinated care that the medical home promotes leads to better health, longer lives, higher patient satisfaction and less expensive care. The question isn’t whether we should implement the medical home, but how.”
- Paul Grundy, MD, IBM Global Director of Healthcare Transformation and President, Patient-Centered Primary Care Collaborative (PCPCC)

## ❖ AAP Preamble to Joint Principles of PCMH

- *Family-centered partnership:* A medical home provides family-centered care through a trusting, collaborative, working partnership with families, respecting their diversity and recognizing that they are the constant in a child's life.
- *Community-based system:* The medical home is an integral part of the community-based system, a family centered- coordinated network of community-based services designed to promote the healthy development and well being of children and their families. As such, the medical home works with a coordinated team, provides ongoing primary care, and facilitates access to and coordinates with, a broad range of specialty, ancillary, and related community services.
- *Transitions:* The goal of transitions is to optimize life-long health and well-being and potential through the provision of high-quality, developmentally appropriate, health care services that continue uninterrupted as the individual moves along and within systems of services and from adolescence to adulthood.
- *Value:* Recognizing the importance of quality health care, appropriate payment for medical home activities is imperative. A high-performance health care system requires appropriate financing to support and sustain medical homes that promote system-wide quality care with optimal health outcomes, family satisfaction, and cost efficiency.

# ❖ Our Mission

- ❖ To support clinical team partnerships which drive improvement in member care and population health by sharing relevant, actionable and timely clinical information with our Medical Home Communities

## ❖ Key Values

- ❖ Collaborative partnership

- ❖ Measurement driven

- ❖ Guided by clinical leadership and evidence based medicine

Access to Care	Improve Care of High Risk Patients
Reduce Inappropriate Admissions and Readmissions	Reduce Non Emergent Emergency Room Visits

## ❖ **Arizona Model**

❖ savings driven

## ❖ **Rhode Island Model**

❖ legislated

❖ Including Parents - BT model

❖ Special Needs - Foster Care

❖ First known reference to medical home was 1967 by the AAP Council on Pediatric Practice and emphasized a single location for a patient's records.

## ❖ Updates

❖ EMR, ACA, HIE, AAFP

## ❖ Barriers

## ❖ Payment

- ❖ House bill 2351, HealthCARE Act of 2007, section 201, provides waiver authority for states to implement policies that are consistent with the medical home. Included in this section of the bill is a reimbursement method that is called the Patient Centered Medical Home Reimbursement Methodology. This method recognizes the value of clinical time associated with family education, coordination of care between specialists, and telephone communications, as well as other aspects of providing care to CSHCN.
- ❖ Section 505 of Senate bill 1364, Healthy Kids 2007 Act, includes as provision to establish a Medical Home Demonstration Project (MHDP). The demonstration project will evaluate savings resulting from increased cost efficiencies and decreases in inappropriate emergency room utilization and duplication of health care services.

## ❖ List

# NCQA principles

- ❖ **Personal physician.** Each patient has an ongoing relationship with a personal physician who is trained to provide first contact, continuous and comprehensive care.
- ❖ **Physician-directed medical practice.** The personal physician leads a team of individuals at the practice level who collectively take responsibility for ongoing patient care.
- ❖ **Whole-person orientation.** The personal physician is responsible for providing all of the patient's health care needs or for arranging care with other qualified professionals.
- ❖ **Care is coordinated and integrated** across all elements of the complex health care system and the patient's community.
- ❖ **Quality and safety** are hallmarks of the medical home.
- ❖ **Enhanced access** to care is available through open scheduling, expanded hours and other innovative options for communication between patients, their personal physician and practice staff.
- ❖ **Payment** appropriately recognizes the added value provided to patients who have a patient-centered medical home.

# ❖ PCMH Standards

- ❖ 1. Access and Communication
- ❖ 2. Patient Tracking and Registry Functions
- ❖ 3. Care Management
- ❖ 4. Patient Self-Management and Support
- ❖ 5. Electronic Prescribing
- ❖ 6. Test Tracking
- ❖ 7. Referral Tracking
- ❖ 8. Performance Reporting and Improvement
- ❖ 9. Advanced Electronic Communication

- **Sec. 2703. State option to provide health homes for enrollees** Medicaid beneficiaries with chronic conditions into a health home, and would provide a comprehensive set of medical services, inclu



- **Sec. 2706. Pediatric Accountable Care Organization demonstr** qualified pediatric providers to be recognized and receive payment pediatric ACO would be required to meet certain performance gui services at a lower cost would share in those savings.

- **Sec. 3021. Establishment of Center for Medicare and Medicaid** and Medicaid Services (CMS) a Center for Medicare & Medicaid I and expand innovative payment and delivery arrangements to imp each program. Dedicated funding is provided to allow for testing o Successful models can be expanded nationally. Section 10306 ac consider, including medical homes.

- **Sec. 5301. Training in family medicine, general internal medicine, general pediatrics, and physician assistantship.** Provides grants to develop and operate training programs, provide financial assistance to trainees and faculty, enhance faculty development in primary care and physician assistant programs, and to establish, maintain, and improve academic units in primary care. Priority is given to programs that educate students in team-based approaches to care, including the patient-centered medical home.

**A house divided against itself cannot stand.**

**Abraham Lincoln**

