

Patient and Family Centered Medical Homes

Connecticut Policy Maker Briefing

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Pediatrics**

American Academy of Pediatrics

June 19, 2009

American Academy
of Pediatrics

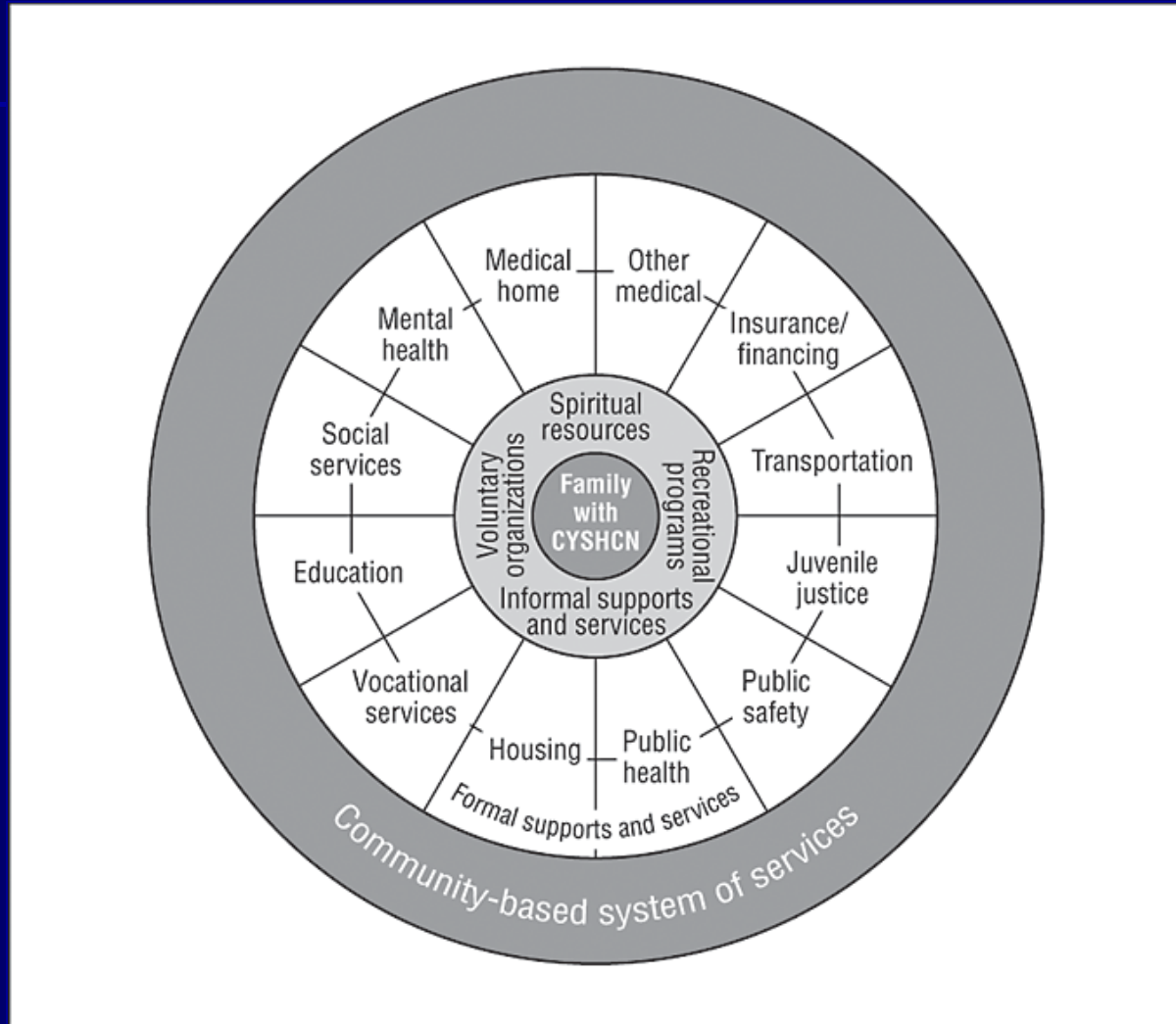


DEDICATED TO THE HEALTH OF ALL CHILDREN™

Medical Home History

- Cal Sia, MD, FAAP
- The American Academy of Pediatrics, Family Voices and the Maternal and Child Health Bureau
- Children and Youth with Special Health Care Needs

Family-centered Community-based System of Services for Children and Youth



Medical Home Definition

- Primary care
- Family-centered partnership
- Community-based, interdisciplinary, team-based approach to care
- **Preventive, acute and chronic care**
- **Quality improvement**

Medical home care is:

- Accessible
- Family-centered
- Coordinated
- Compassionate
- Continuous
- Culturally effective

Medical Homes: Integrated Health *System*

- Patients and Families
- Primary Care Physicians
- Specialists and subspecialists
- Hospitals and Healthcare Facilities
- Public Health
- Community

The Transformation Model

**Structural
Forces**

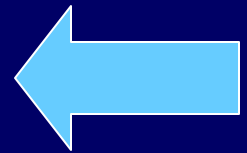


Macro System Environment

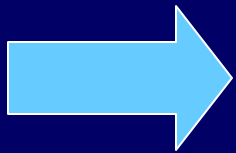
Community

**Family/Patient Centered
Medical Home**

**Regulation &
Legislation
Forces**

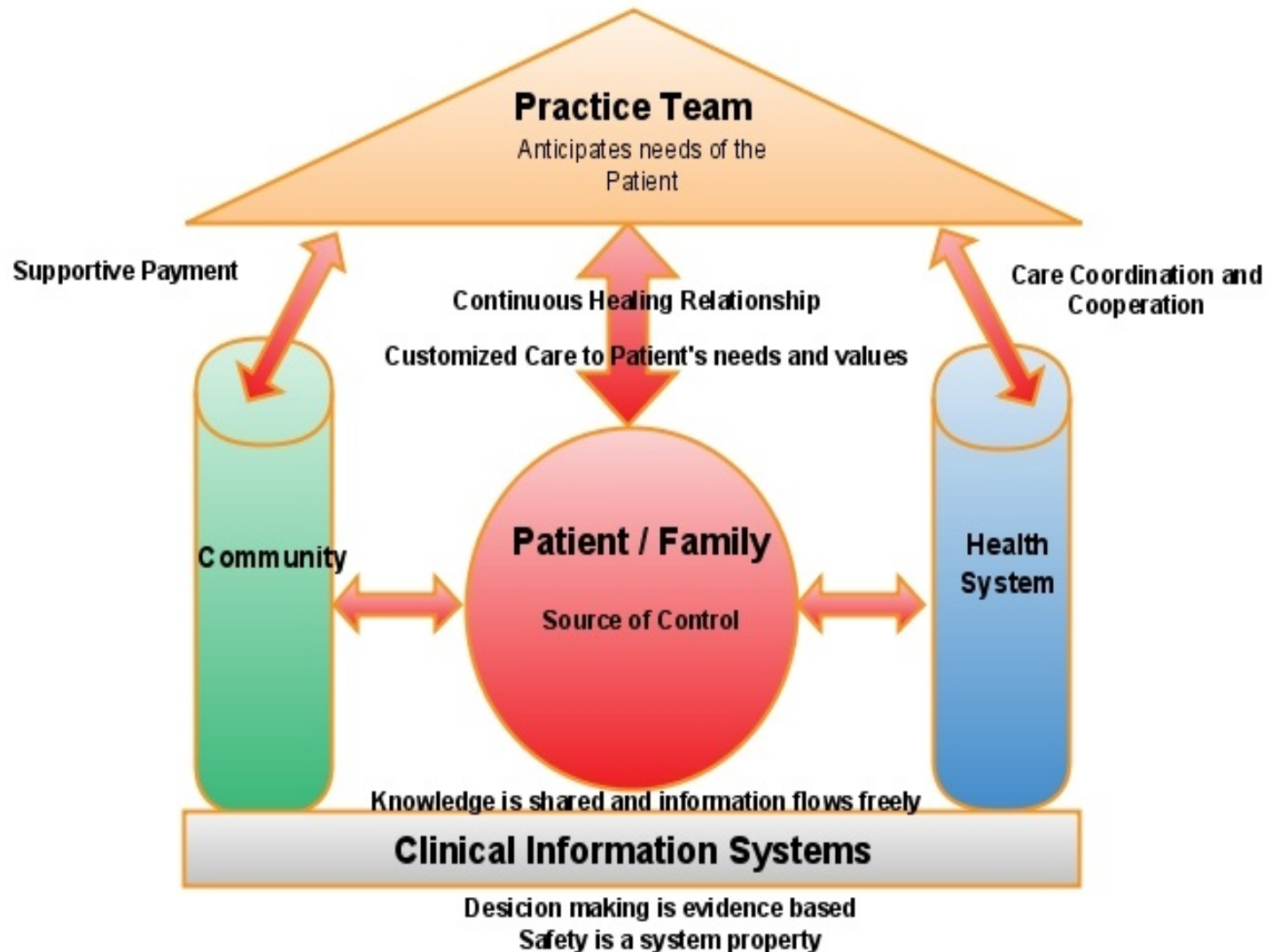


*Cultural,
Social,
Environmental,
Demographic
Forces*



**Finance/Quality
Improvement
Forces**





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: Pediatric Preamble

- Family-centered care
- Community-based system of care
- Transitions
- Value

American Academy
of Pediatrics



DEDICATED TO THE HEALTH OF ALL CHILDREN™

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

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1206 THIS WEEK IN THE JOURNAL

PERSPECTIVE

- 1197 Beyond Pay for Performance — Emerging Models of Provider-Payment Reform M.B. Rosenthal
- 1200 No Place Like Home — Testing a New Model of Care Delivery J.K. Iglehart
- 1202 Building a Medical Neighborhood for the Medical Home E.S. Fisher

ORIGINAL ARTICLES

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- 1218 Five-Year Risk of Colorectal Neoplasia after Negative Screening Colonoscopy T.F. Imperiale and Others
- 1225 Telmisartan to Prevent Recurrent Stroke and Cardiovascular Events S. Yusuf and Others
- 1238 Aspirin and Extended-Release Dipyridamole versus Clopidogrel for Recurrent Stroke R.L. Sacco and Others

CLINICAL PRACTICE

REVIEW ARTICLE

- 1261 Mechanisms of Disease: Platelets, Petechiae, and Preservation of the Vascular Wall R.L. Nachman and S. Rafii

IMAGES IN CLINICAL MEDICINE

- 1271 Primary Small-Bowel Enterolithiasis R.L. Wroblewski and R.P. Sticca

- e13 Colonic Saccular Diverticula E.A. Steensma and F.M. Wu

CASE RECORDS OF THE MASSACHUSETTS GENERAL HOSPITAL

- 1272 A Man with Weight Loss and Abdominal Pain M.A. Goldstein and Others

EDITORIALS

- 1285 Colorectal Cancer Screening on Stronger Footing R.H. Fletcher
- 1287 Stroke Prevention — Insights from Incoherence D.M. Kent and D.E. Thaler

1290 CORRESPONDENCE

- Socioeconomic Inequalities in Health
in 22 European Countries
Contaminated Heparin

Patient-Centered Primary Care Collaborative (PCPCC)

Coalition of over 500:

Major employers

Consumer groups

Primary care physicians

Advocates

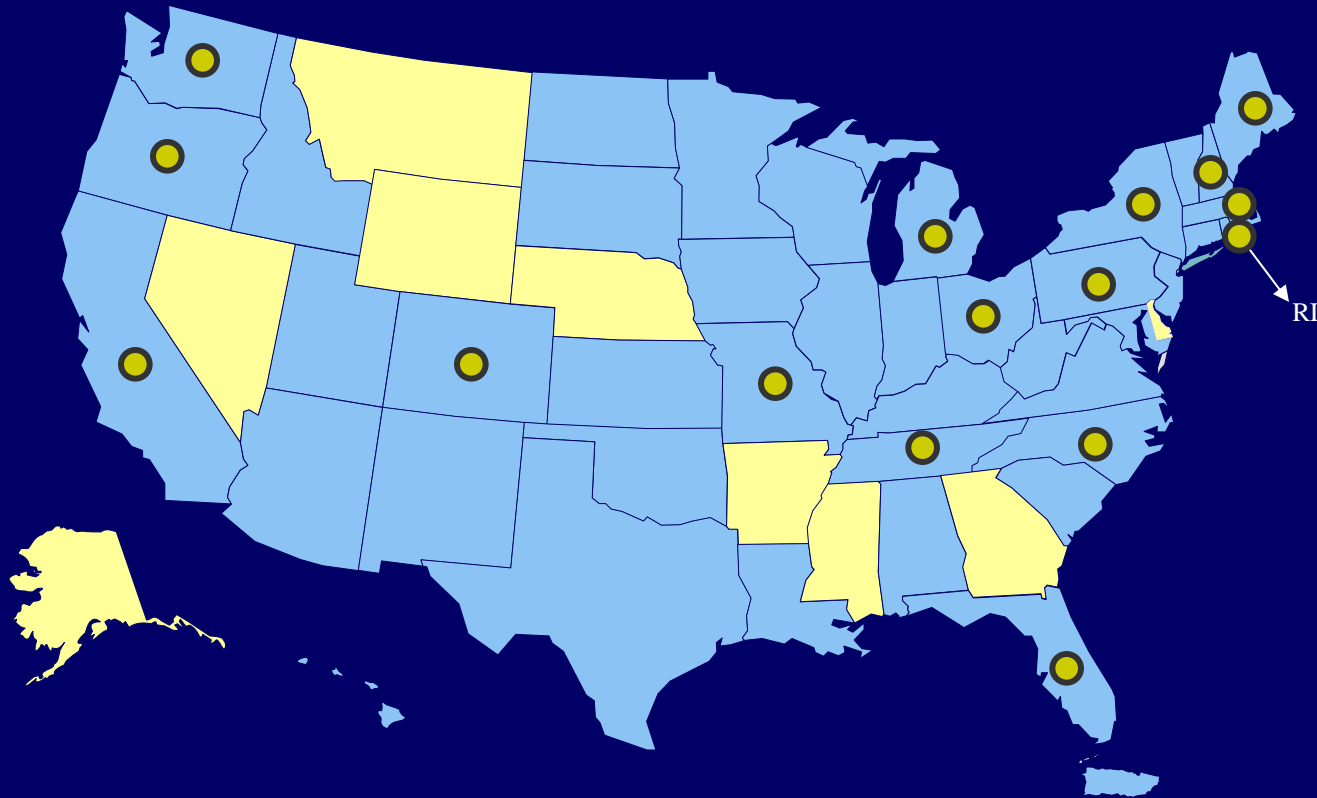
Health Plans

Others

Mission: To advance the patient-centered medical home

Patient-Centered Medical Home

Overview of Current Pilot Activity and Planning Discussions (as of April 2008)



● Multi-Payer pilot discussions/activity

■ Identified pilot activity

■ No identified pilot activity

PCPCC

Prevention

- “Excluding children in medical homes is like building a skyscraper and leaving out the first 10 stories”.

Martin Sepulveda, MD,FACP
Vice President Integrated Health Services
IBM Corporation

Guidelines for Medical Home Demonstration Projects

- Collaboration and leadership
- Practice recognition
- Practice support
- Reimbursement model
- Assessment and Reporting of Results

State Policy Implementation Issues

- Planning and advisory committees
- Defining medical home
- Recognition
 - NCQA
 - State-defined
- Infrastructure and HIT
- Population specifics
- Establishing payment policies
 - Visit
 - Care coordination
 - Quality measurement
 - Infrastructure
- Practice coaching
- Patient education
- System education
- Care transitions
- Measurement

Existing Medicaid/CHIP Structures that Support Medical Home*

- Unique benefits
 - EPSDT
 - Outreach, screening, follow-through
- Health Information Technology
 - Many states used Transformation Grants to build HIT/HIE
 - Medicaid Information Technology Initiative (MITA)
 - ARRA
- Targeted case management
 - States may already do this for set of beneficiaries
 - Includes assessment, care plan development, referral and follow-up
- Disease management
 - Many states have DM
 - Concept evolution

**Adapted from: State and Local Policy Update: How states can (and are) advancing medical homes – Neva Kaye, National Academy for State Health Policy, August 2008*

State Policy Implementation

■ Introduced Legislation in 2009

California	Nebraska	Washington
New Jersey	West Virginia	
Hawaii	New Mexico	Wyoming
Maryland	Texas	

■ Introduced Legislation in 2008

Iowa	New York	Maryland
Kansas	Oklahoma	Maine
Massachusetts	Minnesota	Vermont
New Hampshire	Washington	Utah

■ Enacted Legislation in 2007 and 2008

Colorado	Iowa	Maine
Louisiana	Washington	New York
Minnesota	Oklahoma	

Payment for Medical Homes

- Medicaid and SCHIP funding
- National and State MH Pilots: Medicaid and Multipayer
- Payment structure: hybrid funding
 - Infrastructure
 - Fee For Service
 - Enhanced PMPM
- Coding
- Measurement of MH Activities: NCQA

NCQA: Patient-Centered Medical Home Measurement and Recognition

- Access and communication
- Patient tracking and registries
- Care management
- Patient self management
- Electronic prescribing
- Test tracking
- Referral tracking
- Performance reporting and improving
- Enhanced electronic communications



BUILDING YOUR MEDICAL HOME

brought to you by...



NATIONAL CENTER FOR
MEDICAL HOME
IMPLEMENTATION

HOME

START BUILDING

MEDICAL HOME STANDARDS (NCQA)

QUALITY IMPROVEMENT BASICS

MEDICALHOMEINFO.org

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.

What this Toolkit can do for your practice...

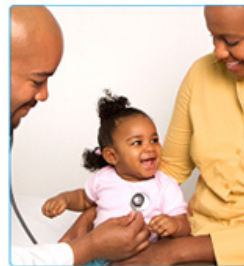
The Toolkit supports your development and/or improvement of a pediatric Medical Home for your patients and families. It also prepares you to score well in your application process to the



National Committee for Quality Assurance (NCQA) Physician Practice Connections® -Patient-Centered Medical Home (PPC-PCHM™) recognition program. Each of the Toolkit building blocks is cross-walked with the NCAQ PPC-PCHM recognition 'must pass' elements.

Why is it 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, family functioning.* The NCQA PPC-PCHM standards provide a way to qualify and quantify care in the Medical Home. In some cases, higher NCQA scores may result in enhanced payment to the practice.



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GO

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



Dr. Jennifer Lail, MD
Chapel Hill Pediatrics
and Adolescents
North Carolina



Dr. David Tayloe, MD
Goldsboro Pediatrics
North Carolina

How to begin

The Toolkit is organized into six building blocks that provide guidance for Medical Home implementation with links to downloadable tools.

- 1 Care Partnership Support
- 2 Clinical Care Information
- 3 Chronic Condition Management
- 4 Resources & Linkages
- 5 Practice Performance Measurement
- 6 Payment & Finance

Get started >>

START BUILDING

Ongoing Medical Home Implementation Issues

- **Definition of Medical Home**
- **“Consumer” knowledge and involvement**
- **Evaluation of Pilots**
- **HIT**
- **Certification vs Recognition**
- **Training and education**

Medical Home Implementation Issues

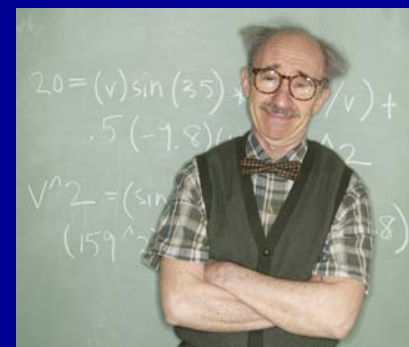
- **Measurement and Performance Standards**
- **Payment**
- **Subspecialty involvement/comanagement**
- **Health care reform**

What we know about medical home care:

- Family satisfaction increases
- Provider satisfaction increases
- Reduced ED use
- Reduced hospital days
- Reduced redundancy
- Reduced cost of care per child (CCHAP)
- Increase in immunization rates and preventive care visits (CCHAP)



...and it is the kind of quality health care that we *all* want, need and deserve for ourselves and our families.



Thank you.

For more information, contact AAP
National Center for Medical Home
Implementation

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AAP Medical Home website:

www.medicalhomeinfo.org

Patient Centered Primary Care Collaborative

www.pcpcc.net