

Medical Home: Old Paradigms/New Direction

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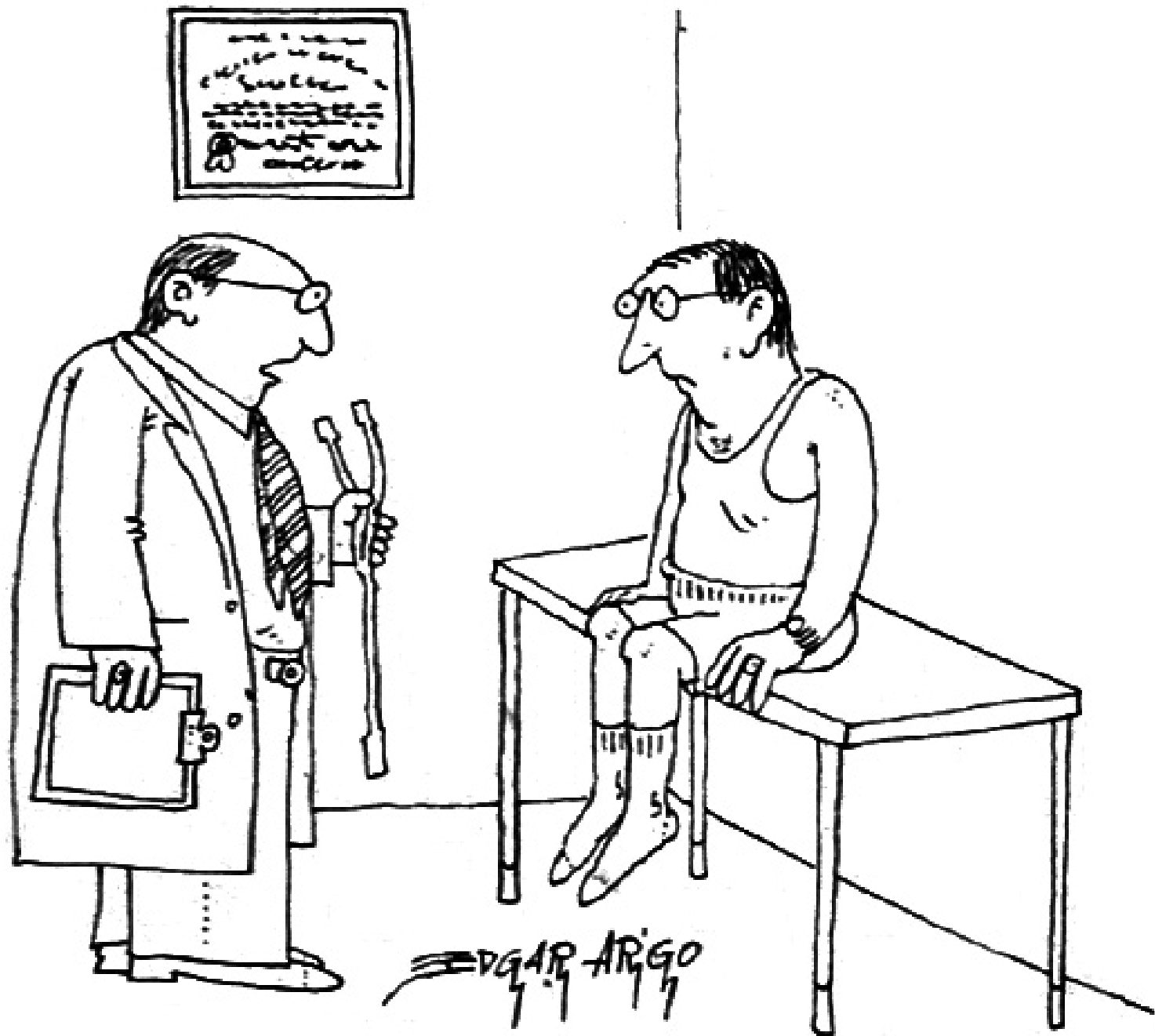
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Old Paradigms/ New Direction

- Objectives:
 - Provide overview of the concept
 - Provide background on work in Minnesota
 - Review state legislation, state initiatives
 - Review private activities--DIAMOND, ICSI, others
 - Identify opportunities/challenges for moving forward



There no improvement, Henry. Are you sure
you're given up *everything* you enjoy?

Issues confronting us all

- Aging population
- 130 million Americans with 1 or more chronic disease
- Poor quality and rising costs
- Disparities in access and quality of care
- Fractured health care system

What are we trying to fix?

- Fragmented care
- Confused, frustrated patients
- Confused, frustrated providers
- Poor coordination of services
- Poor communication at all levels
- “Siloes” of delivery of care
- Poor outcomes in many areas

Why is this happening?

- Prominence of acute care delivery model
- History of “guild” approach-- strong individuality of providers
- Perverse incentives of payment system
- Lack of focus on patient’s needs
 - Heavily provider based system

What is a Medical Home?

- An approach to providing patient care which is:
 - Accessible
 - Continuous
 - Comprehensive
 - Family centered
 - Coordinated
 - Compassionate
 - Culturally effective

Principles of Medical Home

- Personal physician
- Physician-directed medical practice
- Whole person orientation
- Coordinated/integrated care
- Quality and safety key attributes
- Enhanced access
- Payment model reform

Joint statement from AAFP, AAP, ACP, AOA



What should it look like?

- Partnership with patients at all levels of care
- Team based approach to care
- Linkages to community resources are critical
- Systems and roles to support patient in their “navigation” of health care
- Improved information systems to
 - Track and monitor progress
 - Interface between providers at all levels
- 9 • Evaluate outcomes

History of Medical Home in Minnesota

- Mid 90's – MCSHCN commitment to Medical Home
- 2003 – Medical Home Learning Collaborative – MCHB funded
- 2005 – Minnesota Medical Association – Healthy Minnesota endorses Medical Home
- 2007- First “medical home” legislation- Provider Directed Care Coordination (now Primary Care Coordination)
- 2007- Governor’s Healthcare Transformation Taskforce and Legislature’s Health Care Access Commission both endorse Medical home
- 2008- Health Care reform legislations requires “health care homes”



Minnesota history from 2004

- Medical home learning collaborative
 - Pediatric practices
- 21 sites
- Over 5000 children
- Major study of public patients in MH underway

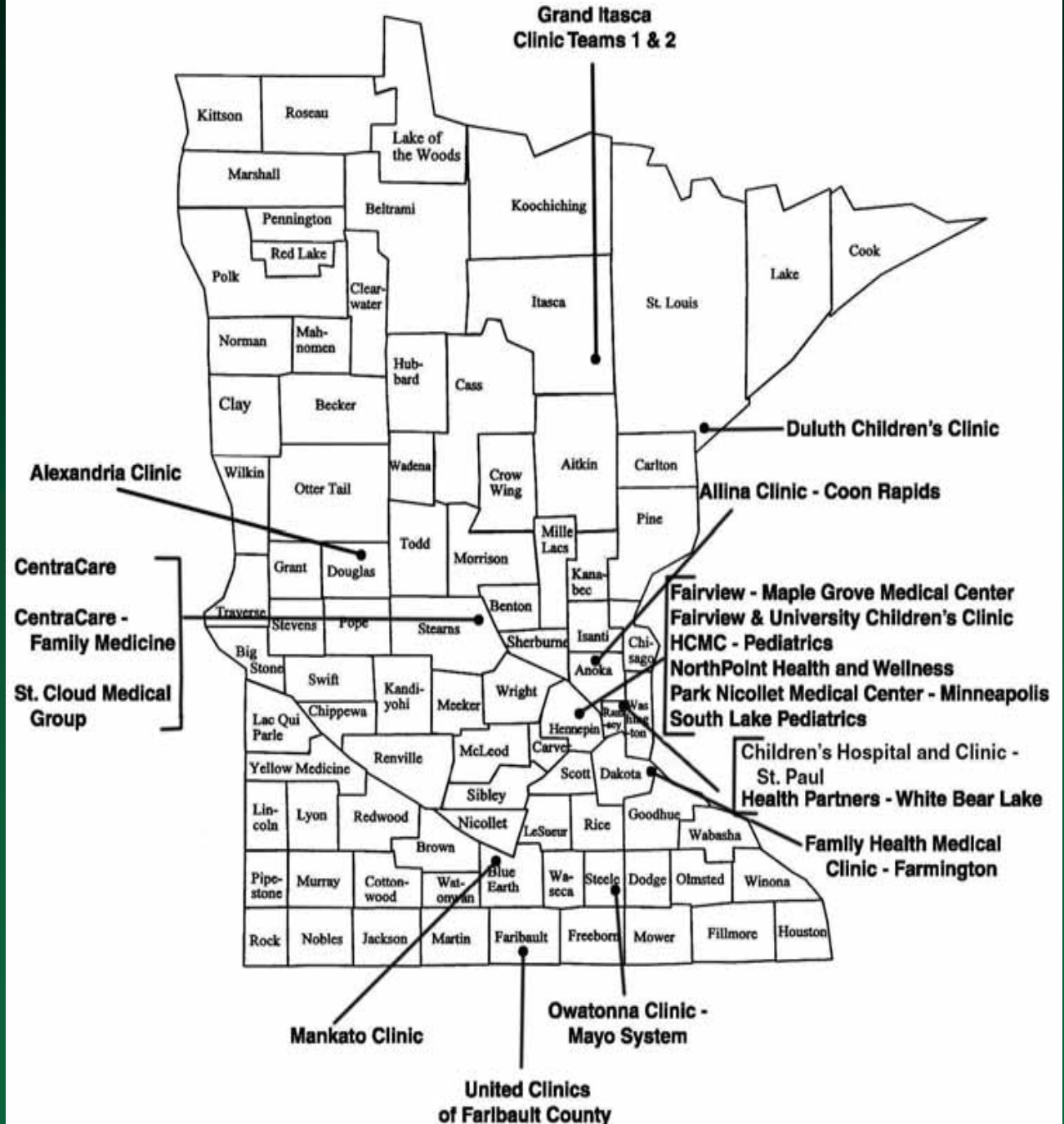


Breakthrough learning collaborative

- 21 teams
- Triennial state meetings – learn about
 - Medical home and components
 - Change management
- Meet every two weeks in the intervals to plan and implement change at the practice level
- PDSA experts



Active Medical Home Teams January 2008



MN Medical Home Learning Collaborative: 20 Teams and Growing...



Learning collaborative

Social structure to support system change

- Teach MH principles
- Model for improvement

How to ride the bike and where to go!



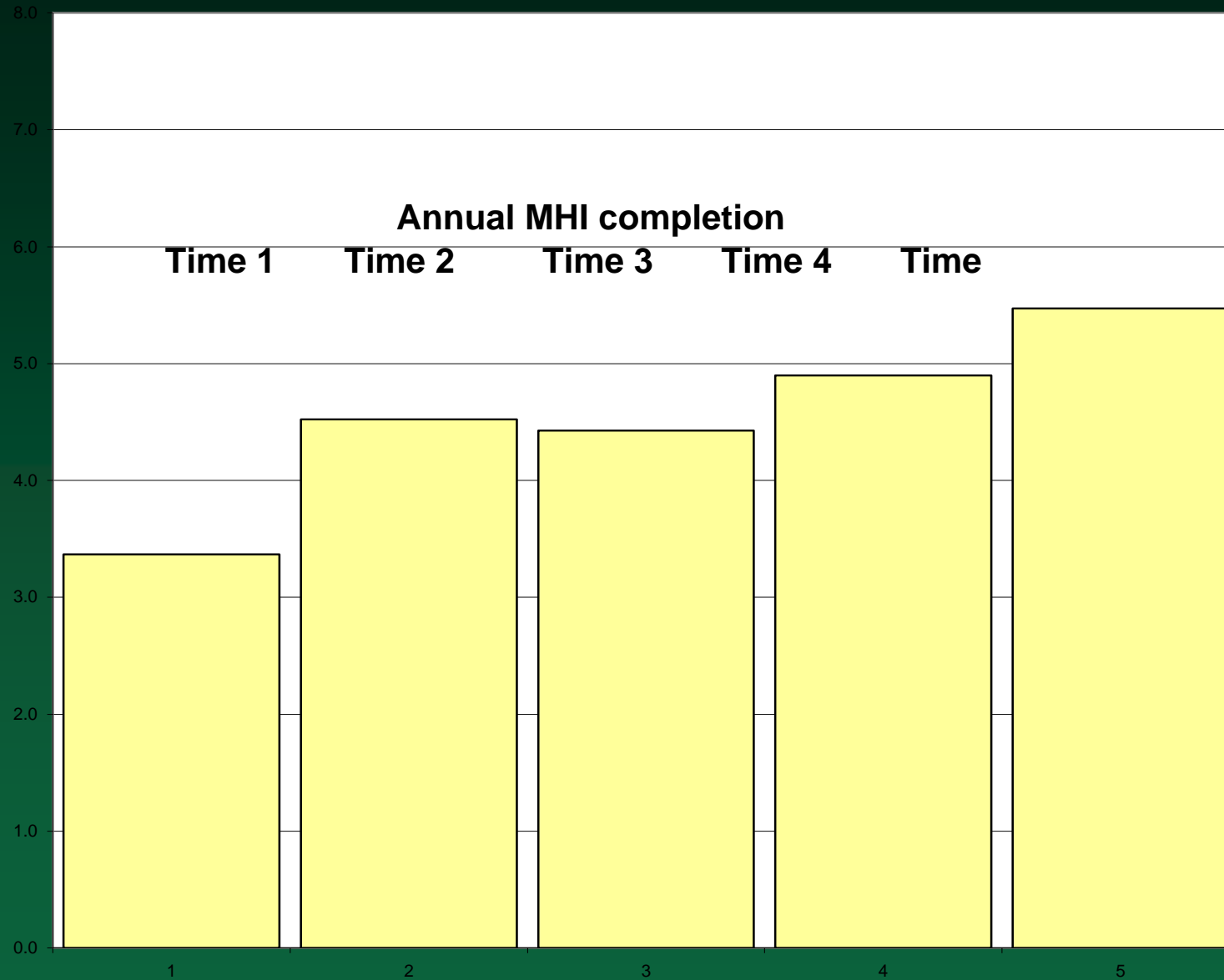
Clinical microsystem

- A *small group* of people who work together in a defined setting on a regular basis to provide care and the *individuals* who receive that care.
- It has clinical and business *aims*, linked *processes*, a shared *information* environment and produces services and care which can be measured as performance *outcomes*. These systems evolve over time and are (often) *embedded* in larger systems/organizations.
- As any living adaptive system, the microsystem must: (1) do the work, (2) meet staff needs, (3) maintain themselves as a clinical unit.

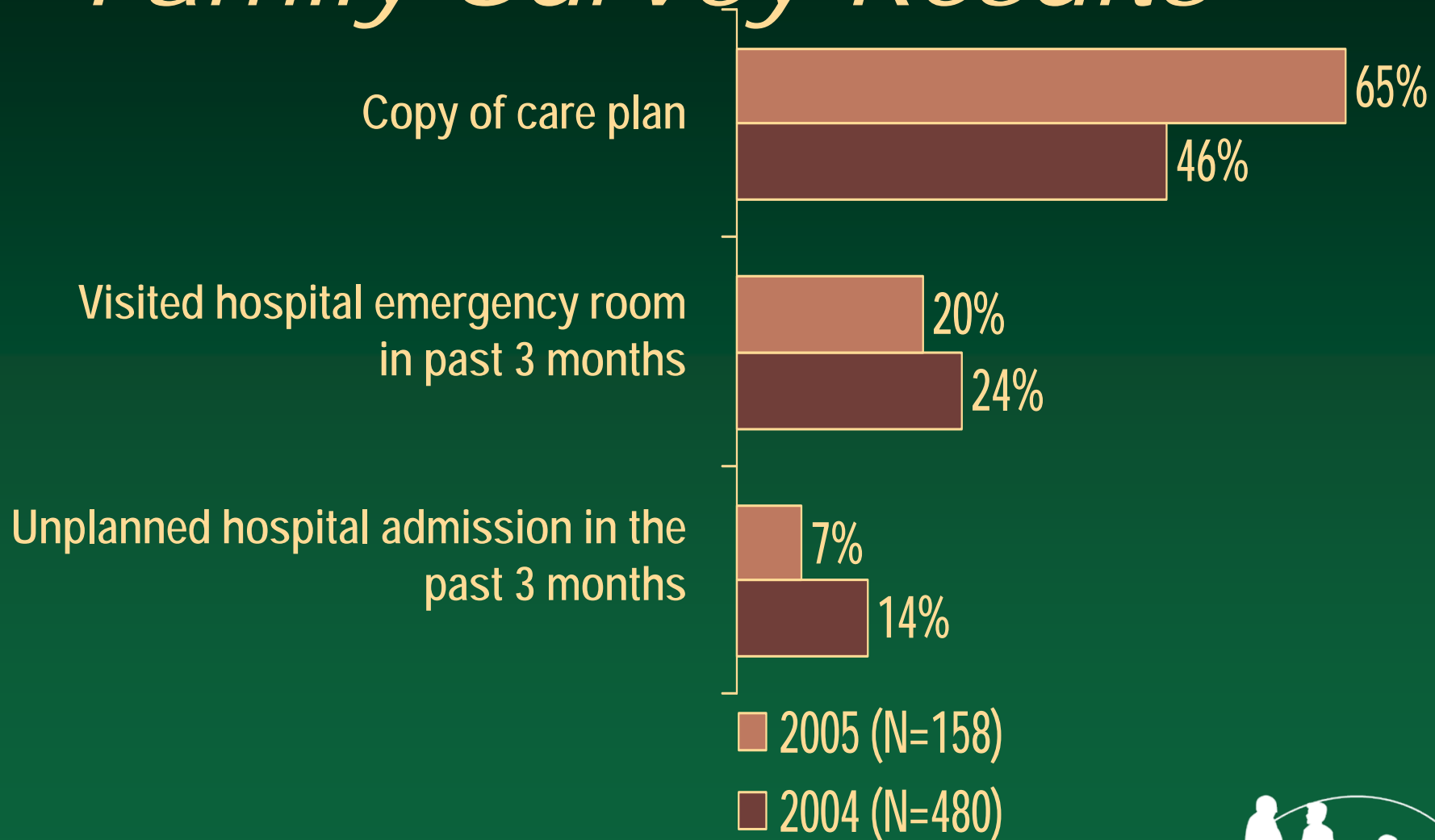
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Medical Home Index: Overall Improvement (mean)



Family Survey Results



Legislation

2007 Provider Directed Care Coordination
Care Coordination grants
2008 Health Care Home



Statute language - 2007

“The commissioner shall develop and implement a provider-directed care coordination program for medical assistance recipients ... who are receiving services on a fee-for-service basis. *This program provides payment to primary care clinics for care coordination for people who have complex and chronic medical conditions. Clinics must meet certain criteria such as the capacity to develop care plans; have a dedicated care coordinator; and have an adequate number of fee-for-service clients, evaluation mechanisms, and quality improvement processes to qualify for reimbursement.* For purposes of this subdivision, a primary care clinic is a medical clinic designated as the patient's first point of contact for medical care, available 24 hours a day, seven days a week, that provides or arranges for the patient's comprehensive health care needs, and provides overall integration, coordination and continuity over time and referrals for specialty care.”



Model development

- ~ 200,000 of 670,000 clients in our Fee for service population
- ~106,000 disabled
- Calculation of 5% savings per client per year compared to similar clients (patients would have annual health care costs over \$12,000)
- For a clinic seeing 100 patients with this level of care coordination need - $\$50 \times 12 \text{ months} \times 100 \text{ patients} = \$60,000$
- Initial budget page based on serving 2500 patients after two years



Implementation of 2007

- Patient selection
- Rates
- Component services



Patient selection

Concepts

- Diagnosis and utilization based stratification of patient population to allow entry and create rate bands
- All enrollees enter screener data about the effect of disease burden on health status



Rates

Concepts

- Based on time studies and potential changes in acute care costs
- One rate per level
- Track over time / expect improved coding
- Expect adjustment to rates over time to use alternative information to assess complexity



Component Services

DRAFT

- Care coordination
- Registry
- Care Plan
- Quality improvement



Outcomes evaluation

- Numbers served
- Geographic distribution
- Impact on disparities
- Quality outcomes
 - Preventative services/heart disease/diabetes/asthma/depression/others
- Patient engagement
- Utilization



2008 Legislation: Summary

- Public health funding
- Health care home
- Increased access
- Price and quality transparency



Guiding principles

- The purpose of the health care reform initiative is to improve the health of Minnesotans and to redesign care to improve value (quality/costs).
- We must “start with the end in mind” and always remain focused on what we want to accomplish and what success looks like.
- To ensure that all Minnesotans benefit from the reforms, we should aim for market-wide implementation of reformed processes—not just processes for government programs.
- We will seek—and expect—unprecedented collaboration among public and private partners as we implement the comprehensive health reform initiative.



Health Care Homes

For Patients with Chronic and Complex
Conditions in all State Health Care Programs

Standards developed and implemented by July
1, 2009

Joint DHS / MDH process

Will incorporate and expand various definitions
of Medical Home



2008 Legislation

In developing HCH standards DHS/MDH must:

Consult with a broad range of stakeholders

Patients and families

Other national and local HCH models

Physicians and other professionals

Health Plans

Hospitals

Advocates

PCC Workgroup may satisfy this criteria



2008 Legislation

DHS/MDH Health Care Home standards must:

Encourage active participation by the patient / family

Encourage the use of primary care

Encourage “top of the license” practice

Provide ongoing, consistent contact with a clinician

Focus on efficient and effective health care services

Encourage the use of scientifically based health care

Encourage patient decision aids

Ensure the use of HIT / patient registries

Ensure each patient has a comprehensive care plan



2008 Legislation

Other HCH certification requirements:

Clinics that choose to become certified must participate in:

- Learning collaborative

- Quality improvement processes & measures

- Patient / family surveys

- Data collection

- Patient screening and identification



2008 Legislation

Payment Restructuring

DHS, in coordination with MDH, shall develop per-person, care coordination payment rates for HCH services

The Care Coordination Fee will be:

Based on patient care complexity, incorporating:

Diagnosis(es)

Social and cultural determinants

Predictive modeling

Developed by January 1, 2010

Implemented by July 1, 2010,

or upon federal approval



2008 Legislation

Payment Restructuring, cont.

By January 1, 2010

All Health Plans must include HCHs in their networks

By July 1, 2010

All Health Plans must pay a care coordination fee to certified health care homes

The Commissioner of Finance must implement a care coordination fee in SEGIP



Legislation requires development of

- **Criteria** for Health Care Homes
- **Verification** of HCH practices
- Development of **rate** methodology to pay for HCH
- **Learning collaboratives**
- Measurement of **outcomes**



Private sector activities

- CentraCare--pediatric model
- Medica--sponsoring support for diabetes care, lipid management
- DIAMOND--medical home for a specific condition
- Multiple local efforts--Mayo, Park Nicollet, St. Mary's/Duluth, Fairview, Northpoint, etc.



Medical Home Forum-ICSI

- July 10, 2008 meeting
- 28 attendees
 - Payers, Department of Human Services, Department of Health, Providers, Purchasers, Patients
- Focus on identification and clarification of efforts--commonalities, differences
- Identify potential future opportunities

Key areas of alignment in Minnesota

- Transformational improvement to health care system may be possible
- Need a collaborative approach to be successful
- Patient engagement at local clinic level is key element
- Practice level QI essential
- Connections to the community critical
- Enhanced by EMR/EHR
- Need agreement on standards/criteria

Key areas needing more discussion

- Primary care/specialty care/behavioral health--one or all
- Payment reform--blending process vs. outcomes criteria
- How to train/certify, and in what areas
- Convener of the collaborative work moving forward

Challenges

- Too many definitions, too little agreement
- Dealing with/changing the culture of health care
- Traversing the political complexity
 - Impact of legislation--tight time frames
- Creating an equitable payment model
 - Need for a critical mass of payers
- Distinguishing from social service case management

Challenges

- Too much expectation from enhanced technology as solution
- Engaging patients in all areas of planning
- Failing to address social and mental health complexity
 - Continuing our history of “medical” model solely

Next Steps

- Developing model for moving collaborative forward
 - Using DIAMOND experience
 - Trying to link with State efforts
- Development of Health Care Home Steering Committee--ICSI facilitate
 - Multiple stakeholders
 - Explore connection to state directives
- Health Plan forum--identify present HCH activities

Next Steps

- Linkages to national efforts to develop social networks
- “Affinity groups” --maximize input
- Dealing with political reality, parallel vs. converging efforts