TABLES FOR MEDICAL HOME WEBINAR

from

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For more information, contact Debbie Peikes (dpeikes@mathematica-mpr.com) or Apu Zutshi (azutshi@mathematica-mpr.com) or visit http://www.PCMH.AHRQ.gov

TABLE 1. OVERVIEW OF THE 12 INTERVENTIONS REVIEWED

Intervention	Overview	Sources Cited
Aetna's Embedded Case Managers	Nurse case managers are assigned to work in primary care practices to help manage care for Medicare Advantage members and collaborate with the clinical team.	Hostetter, 2010
Care Management Plus	Nurse care managers supported by specialized health IT tools within primary care clinics orchestrate care for chronically ill elderly patients.	Agency for Healthcare Research and Quality, 2010; Dorr et al., 2008.
Community Care of North Carolina	Community-based care management provided through networks of primary care physicians (PCPs), a hospital, the Department of Social Services, and the health department. Case managers from a nonprofit work with PCPs in the network to coordinate care and undertake population health management.	Domino et al., 2009; Lodh, 2005; Ricketts et al., 2004; Steiner et al., 2008; Wilhide and Henderson, 2006.
Geisinger Health System ProvenHealth Navigator	Geisinger Health Plan provided one nurse case manager for every 900 Medicare Advantage patients in each primary care practice to identify high-risk patients, design patient-centered care plans, provide care coordination and care transition support, and monitor patients using patient-accessible electronic health records.	Gilfillan, 2010; Graff, 2009; Paulus, Davis, and Steele, 2008; Steele et al., 2010.
Geriatric Resources for Assessment and Care of Elders (GRACE)	Advanced practice nurse and social worker (GRACE support team) assess low-income seniors in home, and develop and implement a care plan with a geriatrics interdisciplinary team, in collaboration with the patient's PCP.	Bielaszka-DuVernay, 2011; Counsell et al., 2009; Counsell et al., 2007; Counsell et al., 2006.
Group Health Cooperative Medical Home	Group Health redesigned one pilot clinic to be a PCMH by changing staffing, scheduling, point-of-care, patient outreach, health IT, and management; reducing caseloads; increasing visit times; using team huddles; and rapid process improvements.	Group Health News, 2010; Reid et al., 2010; Reid et al., 2009.
Guided Care	Guided Care nurse joined primary care practice and provides assessments, care plans, monthly monitoring, and transitional care to highest-risk Medicare patients.	Boult et al., 2011; Boyd et al., 2010; Guided Care Web site, 2010; Leff et al., 2009; Marsteller et al., 2010; Wolff et al., 2009; Wolff et al., 2010.
Improving Mood-Promoting Access to Collaborative Treatment for Late-Life Depression (IMPACT)	Depression care for elderly depressed patients is integrated into primary care via a depression clinical specialist care manager (a nurse or psychologist), who coordinates care among the PCP, a consulting PCP, and a psychiatrist.	Hunkeler et al., 2006; IMPACT Implementation Center Web site, 2010; Levine et al., 2005; Unützer et al., 2001; Unützer et al., 2002; Unützer et al., 2008.
Merit Health System and Blue Cross Blue Shield (BCBS) of North Dakota Chronic Disease Management Pilot	BCBS embedded a chronic disease management nurse in the clinic for patients with diabetes. The nurse assesses the patients' knowledge of diabetes, sets goals for disease self-management, establishes the need for in-person or telephone followup, and refers patients to services.	Fields, Leshen, and Patel, 2010; McCarthy et al., 2008.
Pediatric Alliance for Coordinated Care	A pediatric nurse practitioner from each practice allocates 8 hours per week to coordinate the care of children with special health care needs and make expedited referrals to specialists and hospitals; a local parent of a child with special health care needs provides consultations to the practice.	Palfrey et al., 2004; Silvia, Sofis, and Palfrey, 2000.
Pennsylvania Chronic Care Initiative	Integrates the chronic care model and the medical home model for patients with diabetes and pediatric patients with asthma and includes the following key components: patient-centered care, teaching self-management of chronic conditions, forming partnerships with community organizations, financial incentives for providers, and making data-driven decisions.	AcademyHealth State Health Research and Policy Interest Group, 2009; Chronic Care Management, Reimbursement and Cost Reduction Commission, 2008; Houy, 2008; Torregrossa, 2010.
Veterans Affairs Team-Managed Home-Based Primary Care	Comprehensive and longitudinal primary care provided by an interdisciplinary team that includes a home-based primary care (HBPC) nurse in the homes of veterans with complex, chronic, terminal, and disabling diseases.	Department of Veterans Affairs, 2007; Hughes et al., 2000.

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TABLE 2. SNAPSHOT OF FINDINGS FROM RIGOROUS STUDIES

	Statistically Significant		Inconclusive	
Intervention	Favorable	Unfavorable	Not Statistically Significant	Uncertain Statistical Significance
Processes of Care				
Geriatric Resources for Assessment and Care of Elders			✓	✓
Care Management Plus (CMP)			✓	✓
Improving Mood–Promoting Access to Collaborative Treatment for Late-Life Depression	✓		✓	
Health Outcomes				
Geriatric Resources for Assessment and Care of Elders	✓		✓	
Improving Mood–Promoting Access to Collaborative Treatment for Late-Life Depression	✓		✓	
Veterans Affairs Team-Managed Home-Based Primary Care		✓	✓	
Mortality				
Care Management Plus (CMP)			✓	✓
Geriatric Resources for Assessment and Care of Elders			✓	
Cost				
Geriatric Resources for Assessment and Care of Elders	✓	✓	✓	
Guided Care			✓	
Improving Mood–Promoting Access to Collaborative Treatment for Late-Life Depression			✓	
Veterans Affairs Team-Managed Home-Based Primary Care		✓		
Hospital Use				
Care Management Plus (CMP)			✓	✓
Geisinger Health System	✓			
Geriatric Resources for Assessment and Care of Elders	✓		✓	
Guided Care			✓	
Veterans Affairs Team-Managed Home-Based Primary Care	✓		✓	
Emergency Department Use				
Care Management Plus (CMP)			✓	✓
Geriatric Resources for Assessment and Care Of Elders	✓		✓	
Guided Care			✓	

TABLE 2. SNAPSHOT OF FINDINGS FROM RIGOROUS STUDIES (CONTINUED)

	Statistically Significant		Inconclusive	
Intervention	Favorable	Unfavorable	Not Statistically Significant	Uncertain Statistical Significance
Patient Experience				
Guided Care			✓	✓
Improving Mood–Promoting Access to Collaborative Treatment for Late-Life Depression	✓			
Veterans Affairs Team-Managed Home-Based Primary Care	✓		✓	
Caregiver Experience				
Guided Care			✓	✓
Veterans Affairs Team-Managed Home-Based Primary Care	✓		✓	
Health Care Professional Experience				
Guided Care			✓	✓

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TABLE 3. DETAILED FINDINGS FROM RIGOROUS STUDIES

Intervention	Statistically Significant		Inconclusive	
	Favorable	Unfavorable	Not Statistically Significant	Uncertain Statistical Significance
Processes of Care				
Geriatric Resources for Assessment and Care of Elders			**1 Year:** 2 process of care measures	**1 Year:** 16 process of care measures
Care Management Plus			**1 year:** Preventive Quality Indicator (PQI) hospitalizations among all patients, patients with diabetes, and patients without diabetes **2 years:** PQI hospitalizations among all patients	**2 years:** PQI hospitalizations among patients with and without diabetes
Improving Mood–Promoting Access to Collaborative Treatment	**3 months; 6 months**: Increased rates of antidepressant use, psychotherapy **1 year**: Increased rates of antidepressant use, psychotherapy **1.5 years; 2 years**: Increased rates of antidepressant use		**1.5 years; 2 years:** Rates of psychotherapy	
Health Outcomes				
Geriatric Resources for Assessment and Care of Elders	**2 years:** Improved 4 of 8 Short Form (SF)-36 scales		**2 years:** 4 of 8 SF-36 scales, Activities of Daily Living (ADLs), Instrumental Activities of Daily Living (IADLs), and days in bed	

TABLE 3. DETAILED FINDINGS FROM RIGOROUS STUDIES (CONTINUED)

Intervention	Statistically Significant		Inconclusive	
	Favorable	Unfavorable	Not Statistically Significant	Uncertain Statistical Significance
Improving Mood–Promoting Access to Collaborative Treatment	**3 months; 6 months:** Reduced depression symptoms, overall impairment; improved overall quality of life **1 year:** Reduced depression symptoms, overall impairment; improved SF-12 physical component score, quality of life, general health **1.5 years:** Reduced depression symptoms, overall impairment; improved SF-12 physical component score, quality of life, general health **2 years:** Reduced depression symptoms, improved SF-12 physical component score, quality of life, general health		**2 years:** Overall impairment	
Veterans Affairs Team-Managed Home-Based Primary Care		**1 year:** Worsened 1 of 8 SF-36 scales for nonterminal patients	**1 year:** Barthel index for nonterminal patients, 7 of 8 SF-36 scales for nonterminal patients	
Mortality				
Care Management Plus			**2 years:** All patients	**1 year:** All patients and patients with diabetes **2 years:** Patients with diabetes
Geriatric Resources for Assessment and Care of Elders			**2 years:** All patients	
Cost				
Geriatric Resources for Assessment and Care of Elders	**Year 3:** High risk: Reduced 23%	**Year 1:** All patients: Increased 28% Low risk: Increased 46% **Year 2:** All patients: Increased 14% Low risk: Increased 30% **Year 3:** Low risk: Increased 19%	**Year 1:** High risk **Year 2:** High risk **Year 3:** All patients	
Guided Care			**8 months:** All patients	

TABLE 3. DETAILED FINDINGS FROM RIGOROUS STUDIES (CONTINUED)

Intervention	Statistically Significant		Inconclusive	
	Favorable	Unfavorable	Not Statistically Significant	Uncertain Statistical Significance
Improving Mood–Promoting Access to Collaborative Treatment			**4 Years:** All patients	
Veterans Affairs Team-Managed Home-Based Primary Care		**Months 1 - 12:** Increased 12%		
Hospital Use				
Care Management Plus			***Odds of hospitalization*** **Year 1:** All patients Patients without diabetes **Year 2:** All patients Patients without diabetes	***Odds of hospitalization*** **Year 1:** Patients with diabetes **Year 2:** Patients with diabetes
Geisinger Health System ProvenHealth Navigator	***Number of stays*** **4 years:** Reduced 18% ***Number of readmissions*** **4 years:** Reduced 36%			
Geriatric Resources for Assessment and Care of Elders	***Number of stays*** **Year 2:** High risk (high Probability of Repeated Admission (PRA) score): Reduced 44% **Year 3:** High risk (high PRA score): Reduced 40%		***Number of stays*** **Year 1:** All patients, high risk (high PRA score) **Year 2:** All patients	
Guided Care			***Number of stays*** **8 Months** **20 Months**	
Veterans Affairs Team-Managed Home-Based Primary Care	***Number of readmissions*** **Months 1–6** Severely disabled: Reduced 22%		***Proportion readmitted*** **Months 1–6:** All patients, severely disabled **Months 1–12:** All patients, severely disabled ***Number of readmissions*** **Months 1–6** All patients **Months 1–12** All patients, severely disabled	

TABLE 3. DETAILED FINDINGS FROM RIGOROUS STUDIES (CONTINUED)

Intervention	Statistically Significant		Inconclusive	
	Favorable	Unfavorable	Not Statistically Significant	Uncertain Statistical Significance
Emergency Department Use				
Care Management Plus			***Odds of an ED visit*** **Year 1:** All patients, patients without diabetes, and patients with diabetes **Year 2:** Patients with diabetes	***Odds of an ED visit*** **Year 2:** All patients and patients without diabetes
Geriatric Resources for Assessment and Care of Elders	***Number of visits*** **Year 2:** All patients: Reduced 24% High risk: Reduced 35%		***Number of visits*** **Year 1:** All patients and high risk patients	
Guided Care			***Number of visits*** **8 Months** **20 Months**	
Patient Experience				
Guided Care			**1.5 years:** ***Decision Support***	**1.5 Years:** ***Care Coordination, Overall Quality of Care, Goal Setting, Problem Solving, Patient Activation***
Improving Mood–Promoting Access to Collaborative Treatment	3 months, 12 months: ***Satisfaction with Care***			
Veterans Affairs Team-Managed Home-Based Primary Care	***1 year:*** ***Access to Care, Interpersonal Experience, Technical Quality, Communication, Self-reported Outcomes*** Nonterminal patients		***1 year:*** ***Satisfaction with Care*** Nonterminal patients	

TABLE 3. DETAILED FINDINGS FROM RIGOROUS STUDIES (CONTINUED)

Intervention	Statistically Significant		Inconclusive	
	Favorable	Unfavorable	Not Statistically Significant	Uncertain Statistical Significance
Caregiver Experience				
Guided Care			**6 months:** ***Caregiver Burden*** All caregivers **18 months:** ***Caregiver Experience with Quality of Care Provided to Patients*** All caregivers: 1 of 6 measures High-intensity caregivers: 4 of 6 measures Low-intensity caregivers: 3 of 6 measures ***Caregiver Burden*** All, high-intensity, and low-intensity caregivers ***Caregiver Productivity*** All, high-intensity, and low-intensity caregivers	**6 months:** ***Caregiver Burden*** High-intensity caregivers **18 months:** ***Caregiver Experience with Quality of Care Provided to Patients*** All caregivers: 5 of 6 measures High-intensity caregivers: 2 of 6 measures Low-intensity caregivers: 3 of 6 measures
Veterans Affairs Team-Managed Home-Based Primary Care	**12 months:** ***Caregiver Experience with Quality of Care Provided to Patients*** Nonterminal patients ***Caregiver Burden*** Nonterminal patients: 1 of 2 measures ***Caregiver Functional Status*** Non-terminal patients: Improved 6 of 8 SF-36 scales		**12 months:** ***Caregiver Burden*** Non-terminal patients: 1 of 2 measures ***Caregiver Functional Status*** Nonterminal patients: 2 of 8 SF-36 scales	
Health Care Professional Experience				
Guided Care			**12 months:** ***Satisfaction with Care Management, Time Spent on Chronic Care, Knowledge of Patients' Personal Circumstances, Coordination of Care*** All patients	**12 months:** ***Satisfaction with Communication, Knowledge of Patients' Clinical Circumstance*** All patients

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