A Patient & Family-Centered Medical Home for All Children
Includes Children/Youth with Special Health Care Needs

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CMHI (Center for Medical Home Improvement) www.medicalhomeimprovement.org

The Primary Care Medical Home
At the crossroads integrating:

- **Vertically** - Among health care systems/specialists/PCPs/patients & families
- **Horizontally** - Among patients & families/community agencies/schools, etc...
- **Continuously** - with continuity of clinicians and medical home team members
- **Longitudinally** - Over time with anticipatory guidance

The Feeding and Nourishing of a Medical Home
A Few Good Food Analogies -

**Pollan & Graumbach**

- *NYTimes* Dr. Graumbach
- Eat food Get health care
- Not too much Not too much
- Mostly plants Mostly primary care

**Nutting et al.** - (Initial lessons from first Transformed demonstration)
Primary care - like healthy food, works best at a local and personal level

**McAllister** Tomatoes … *Animal, Vegetable, Miracle*, by Barbara

<table>
<thead>
<tr>
<th>Local Tomato Grower</th>
<th>Medical Home?</th>
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Local Tomato Grower

Part of the local community ✔
“Barter” or exchange assets ✔
Value health, quality product, and safety ✔
Sell “product” directly to customers ✔
Livelihood is mission as well as business ✔
Customers show up week after week, at a community gathering place ✔
First names common; open door/welcoming policy ✔

Name of the heirloom tomato? She is growing “TRUST”

Medical Home – Timeline – the Pediatric era

1967 – AAP centralized medical record = medical home
1992 – AAP Cal Sia – Hawaii
   Pediatric Medical Home; coordinates care with early intervention
1996 – AAP & MCHB
   Medical Home initiatives - children with special health care needs
   MCHB applies COI methods to office practice change methodology
2003 – Medical Home Index – first quantitative measure of medical homes
   developed, validated, published-CMHI
   MCHB funded partnership between CMHI and NICHQ
   AAP National Center for Medical Home Implementation /Medical Home Toolkit – uptakes CMHI/other tools

Medical Home – Timeline – Primary Care Transformation

2004 – AAFP publishes The Future of Family Medicine
   Medical Home model is the foundation
2006 – ACP promotes Advanced Primary Care
   Uses Medical Home language and model
2007 – Joint Statement on the Primary Care Medical Home
   AAP, ACP, AOA, and AOA
   Medical Home model as the standard of primary care
2007 – Erisa-related Industries Committee launches the Patient-centered Primary Care Collaborative
   Popoc.net, waiting for pediatric incentives
   On the brink (January 2010)
   Medicare Advanced Primary Care Pilot Demonstrations...
   Health Care Legislation/Reform

Families of children with special health care needs (CSHCN*) seek a medical home that:

- Offers a collaborative family-centered, team approach
- Develops a written summary of critical care information
- Has a developed process to integrate and coordinate care across multiple services


Emphasis on partnerships with families

Continuum of ways to engage patients & families, as:

Every Child, Youth & Adult - benefits from a proactive, planned and coordinated Medical Home

Jamie, an 11- yo female, affected by Spina Bifida, arrives at pediatricians for a well child examination.

- Specialists: orthopedist, urologist, and neurosurgeon

- Jamie’s mother has two pressing concerns:
  1) Jamie is pubescent; will likely begin menstruating soon
     - How to handle this event given Jamie’s catheterization program, (both at school and home).
     - Jamie’s father has declared he does not want to be a part of Jamie’s “home team” once menarche has occurred.
  2) Jamie endures teasing at school because her periodic urine leakage leaves an odor.

VISIT
   The office nurse finds that none of the recent specialist’s notes have arrived & the PCP did not plan time to address these concerns today...

* (CSHCN- condition lasts at least 1 year, affects ADL, and requires more than usual medicine/treatments)
Families want and need:

- Offers a collaborative family-centered, team approach
- Develops a written summary of critical care information
- Has a developed process to integrate and coordinate care across multiple services

Jamie in a medical home – partner in proactive, planned, coordinated care

- Time
  - Form trusting partnership with care team.
- Teamwork
  - Help Jamie to take a more active role / progressively planning for increased independence
- Care Plan
  - Develop, use, and share a comprehensive plan of care
- Partner in care
  - Jamie, encouraged, begins to ask questions; she contacts her coordinator for assistance or questions on her own
- Explicit roles
  - Team/family understand their roles
- Prepare for visits - questions, records, evaluations tests available
- Events
  - Coordination & community outreach
  - Gather information about outside events: school/urgent care/ER/hospitalizations - (family understands staff want and need to be informed)
- Leadership
  - Family’s ability to lead is variable/may at times need more active engagement of coordinator & team

Measuring the Medical Home Measured

- Quality Assurance – do you meet standards?
  - National Committee for Quality Assurance (NCQA)
  - 10 Standards; Levels 1, 2 and 3
  - Basic requirement for many pilots
- Quality improvement – where are you on NH continuum?
  - CMHI Medical Home Index – (Validation Study 2003)
  - Medical Home Index & Survey
  - (Pediatric & adult versions; long & short forms)

The CMHI Medical Home Index
6 Domains (25 Themes)

- Organizational Capacity (7)
- Chronic Condition Management (6)
- Care Coordination (6)
- Community Outreach (2)
- Data Management (2)
- Quality Improvement/Change (2)

CMHI Intervention - Redesign

- Aim
- Measurements
- Team/Improvement
  - Clinician, parent partners, care coordinator
- Facilitation/coaching
- Learning sessions/tools
- Cross fertilization
- Measurement

Support for pediatric transformation leads to 30% improvement overall in 3 years, n=10.
Pediatric Medical Home
Family Outcome Data of Significance

- ↑ Family feedback
- ↑ Care plans/summary
- ↑ Health status
- ↓ Parental Worry
- ↓ School absences
- ↓ ER, hospitalizations, & specialty visits

Pre & Post n=83 data sets, (p-value of <0.05)

McAllister, et al; J. Ambulatory Care Management, July-September 2009

CMHI National Outcomes Study – Cost/Utilization

- Medical Home –
  Medical Home Index; 43 Practices, 7 Plans/5 States
  - Higher overall MHI scores or higher domain scores for care coordination, chronic condition management, office organizational capacity
    - Lower hospitalization rates
  - Higher Chronic Condition Management domain scores
    - Fewer ER visits

Cooney, McAllister, Sherrieb, Kuhlthau, Pediatrics, July 2009

Where does practice support come from now?
What does it take?

CMHI lessons learned:

- Patient/family engagement -
  - Guidance & vitality (see continuum of strategies slide)

- Transformation help – support redesign and improvement processes
  - Guide with their personal mastery –
    - Teamwork, access, population approaches, coordinated planned care, technology skills, etc.

- Leadership – alignment of messages from all interested/investing in primary care

- Payment reform – & reinvest payment into primary care infrastructure/coordination of care

CMHI’s TAPP™ (Gap) Analysis:
A Medical Home Assessment with Transformation & Measurement Methods

- Teamwork
- Access & Communication
- Population Approach
- Planned, Coordinated Care
- Patient & Family-Centered Care

CMHI (Center for Medical Home Improvement) www.medicalhomeimprovement.org
CMHI - TAPPP Process

1. TAPPP™ Patient & Family-Centered Medical Home

   Across the lifespan for children, youth and adults

   Reformed Coverage & Continuous Transformation Supports

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References/Resources

- McAllister, J.W., Presler, E., Turchi, R., Antonelli, R.C., Achieving Effective Care Coordination in the Medical Home, Pediatric Annals, Vol 38 No 10, 2009
- AAP "Building Your Medical Home" Toolkit www.pediatricsmedhome.org