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

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MEDICAL HOMES: LIVING, BREATHING, COMPLEX ORGANIZATIONS

CMHI Center for Medical Home Improvement

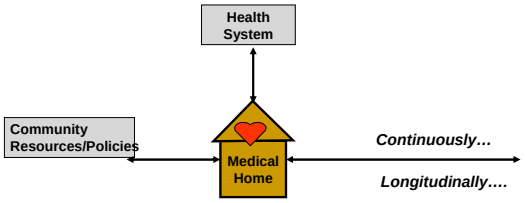
Medical home transformation for high quality care across the lifespan since 1993

Today
1)Discuss CMHI measures, tools and lessons learned - applicable across the lifespan
2)Demonstrate the relationship of high quality pediatric medical homes to elevated outcomes
3)Outline the **CMHI TAPPP™ (Gap) Analysis** process & relate to practice transformation
4)Offer 5 CMHI key lessons learned - germane to primary care for all

The Primary Care Medical Home At the crossroads integrating:

Investment in Primary Care

- 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**

Local Tomato Grower	Medical Home?
Part of the local community	
"Barter" or exchange assets	
Value health, quality products, 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? { ? }

Local Tomato Grower	Medical Home?
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
  - CMHI applies CQI methods to office practice change methodology
- 2003 – **Medical Home Index** – first quantitative measure of "medical homeness" - developed, validated, published-CMHI
- 2003 – 2006 – 1st, 2nd National Medical Home Learning Collaborative
  - 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**, AAFP, ACP, and AOA
  - Medical Home model as *the* standard of primary care
- 2007 – Erisa-related Industries Committee launches the Patient-centered Primary Care Collaborative
  - Pcpcc.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

Kelly A, et al (2002) Pediatrics

Isn't this the same for all patients, and families, at all ages with all needs?

* (CSHCN- condition lasts at least 1 year, affects ADL, and requires more than usual medicines/treatments)

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…

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

▪*Family-Centered*
▪*Team Approach*
▪*Care Coordination*

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 you are on MH continuum?**
  - **CMHI Medical Home Index – (Validation Study 2003)**
    - **Medical Home *Family* Index & Survey**
      - **(Pediatric & adult versions; long & short forms)**

The CMHI Medical Home Index 6 Domains (25 Themes)

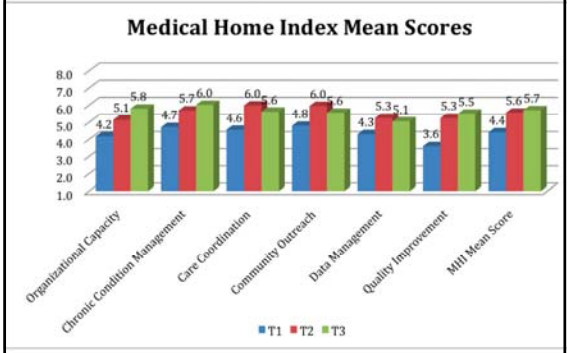
- Organizational Capacity (7)
- Chronic Condition Management (6)
- Care Coordination (6)
- Community Outreach (2)
- Data Management (2)
- Quality Improvement/Change (2)

❑ **Cooley, McAllister, Sherrieb, & Clark; Ambulatory Pediatrics, July 2003**

CMHI Intervention - Redesign

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

Figure 1. Medical Home Index Results at Year 1(T1), Year 2 (T2) and Year 3 (T3)



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

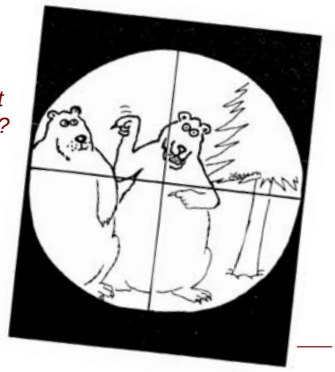
CMHI National Outcomes Study – Cost/Utilization

- 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

Cooley, 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 (Center for Medical Home Improvement) www.medicalhomeimprovement.org

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

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

CMHI - TAPPP Process

(3) TAPPP™ Matched support & resource package - practice team create own work plan - test, innovate &transform

(2) TAPPP™ Gap Analysis, Report & Recommendations

(1) TAPPP™ Intake Assessment

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MEDICAL HOME FERVOR

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Patient & Family-Centered Medical Home

Across the lifespan for children, youth and adults

Reformed Coverage & Continuous Transformation Supports

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References/Resources

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