Implementing the Medical Home - Practical Suggestions -

- Acknowledgement: A Horse of a Different Color?
  - FPs have helped to keep current health system functioning, generously.
  - Many FPs have build already highly functioning Medical Homes – may just need some trim work
  - Compensation due, for all you do
- Blueprint – types of change – work in progress
- Slides organized by Core Principles
- Handout / MAFP Website
- Redundancies b/c of overlap b/n Concepts

Implementing the Medical Home Core Principles

- **Care Coordination –** remember the general goals
- The Personal Physician
- Focus on Quality and Safety
- Patient-Centeredness
- Enhanced Access
- Comprehensive Care
- (Compensation Reform)

Implementing the Medical Home Care Coordination - MnDHS

Evidence-Proven mechanisms for improved care coordination:

- Patient and Disease Registries
- Care Plans
- Care Coordinators
- Community and Subspecialist Engagement
- Patient and Family Engagement
- Practice-Based QI
- Participation in a Learning Collaborative

Idealized MH - Care Coordination -

- **PATIENT HEALTH RECORDS** - must be:
  - Accessible to care team members
  - Viewable efficiently
  - Transmissible
  - Current
  - Substantive, Personalized and Relevant
  - Maintained/Updated continuously by the Personal Physician and clinic team
    - Extrinsic documents
    - Problem lists
    - Meds lists
    - New recommendations/changes to Care Plan
  - Utilized broadly as record of patient's health journey

Idealized MH - Care Coordination -

- **CARE PLANS**: "The Pt's story on 1 page"
  - Comprehensive list of:
    - Needs (language, equipment, social and cultural concerns, patient preferences, etc.)
    - Diagnoses -> current status and care plans
    - Meds, allergies
    - Advanced Directives, Contingency Plans, Health Goals
    - Contact info for all caregivers, including the Personal Physician, active consultants, and Care Coordinator
  - Formulated with patient/family
  - Updated/Monitored each encounter
  - Incorporates EBM guidelines
  - Written/Laminated/FlashDrives - carried by patients
  - 24/7 Plan

Idealized MH - Care Coordination -

- **CARE COORDINATORS**:
  - Medical professional staff w/ dedicated time (RN, PHN, MedSW, MD)
  - For complex or special needs patients
  - Work directly w/ PPs (become point of continuity); help maintain Care Plans
  - Integrate medical/non-medical info for pts
  - Educate patients about diseases and recommendations, and caregivers about the patient

Idealized MH
- Care Coordination -

- Care Coordinators (cont.)
  - Envisioned as planning for, or assuring planning for, all needs of client – care schedules, care needs, med schedules and organization, transportation, $ problem solving, pharmacy service acquisition, data/information transfer to caregivers, tracking clinical recommendations/reminders to pts
  - Especially helpful with integrating community service providers (school staff, therapists, counselors, SWs) into care plans, and with the clinic practice

Idealized MH
- Care Coordination -

- **PATIENT AND FAMILY ENGAGEMENT**
  - Implies partnership:
    - care plan formation, Practice Performance Assessment (Community Boards, QI)
  - Emphasizes need for structured and routine patient/family education:
    - Patient Educators / Personal Physician-Team Nurse
    - Self-education tools
  - Direct Patient Service Interactions:
    - Assistance w/ PHR review
    - Clinical reminders

Idealized MH
- Care Coordination -

- **COMMUNITY AND CONSULTANT ENGAGEMENT**
  - Implies overt “partnering” agreements
    - Schools, NHs, Special Ed, Special Services, PT/OT/ST, consultants, Hospice…
  - Active communication, reliable information flow b/n them and PP/Care Coordinator
  - Requires technological resources, e.g. for:
    - Links to teachers, Tamperproof Prescribing, Formulary and Insurance Coverage interface tools, Links to indigent med acquisition programs…
  - All service providers inserted into care plan

Idealized MH
- Care Coordination –

- Participation in **LEARNING COLLABORATIVE** (Minnesota)
  - Group education
  - Clinic Teams (PPs, CCs, Team nurses, pts, families)
  - Meet regularly
  - Investigate/discuss self-selected clinical process interventions for process and client satisfaction improvement
  - “Minnesota Medical Home Learning Collaborative”
    - (You can “google it” to learn more…)

Idealized MH
- Care Coordination –

- Thorough Planning for needs of client (even for patients not utilizing a CC)
- Clinic and Whole-System Policies:
  - Promote Continuity-Based Care
  - Invite Personal Physician care input at all desired points of care (e.g. hospital, etc.)
  - Create culture of service, inter-professional respect, and encourage and facilitate communication
  - Emphasize importance of primary care in general, and importance of primary care coordination of care, more specifically

Implementing the Medical Home
Core Principles

- Care Coordination
- **The Personal Physician –** continuity, generalism, informed coordinator
- Focus on Quality and Safety
- Patient-Centeredness
- Enhanced Access
- Comprehensive Care
- (Compensation Reform)

Idealized MH
-The Personal Physician -

- Informed Coordinator Role
  - Bridges patients with the “house of medicine”
  - Keeper of Health Record & Care Plan; Engages in QI
  - Accountable Team Leader in clinic
    - W/ care coordinators, SWs, Counselors, Dieticians, Clinical Nurse Specialists, Team nurses, Therapists, Patient Educators
    - Digests team communication about patients
  - Ensures well-designed systems for patient contact, test result communication, follow-up
  - Assures assimilation of outside information
    - “Signs off”/digests incoming documents
    - Updates Problem and Meds Lists and Care Plans
  - Communicates w/ partners (proxies), care team members, consultants

Idealized MH
- The Personal Physician -

- Generalist
  - trained specifically as such
  - sees the big picture – the forest as well as the trees
  - able to help system prioritize decisions according to patient needs/circumstances/preferences
  - tempers the “Disease Management” paradigm tendency toward recipe medicine
  - Is utilized by whole health community as patients’ ‘specializing generalist’
    - Visits to consultants are considered “round trips”, not lateralizing ‘weigh stations’
    - Achieves direct or indirect input into care in other settings – hospital, E.R., NH, or re-delegates the role.

Idealized MH
- The Personal Physician -

- The Point of Continuity
  - Patients want to feel they are “home”

“HOME” is where you’re:
- Safe
- Valued
- Tended
- Known

Idealized MH
- The Personal Physician -

- (Point of Continuity - cont.)
  - Creates relationships of *trust, accountability, familiarity, and caring* with patients, developed over time
  - Clinic policies prioritize placement of pts w/ clinicians who KNOW them:
    - advanced access / walk-in flexibility
    - clinic mini-teams
    - shared practices for part-time docs

Idealized MH
- The Personal Physician -

- Conveyor (in the PC-PCC-MH) of patient’s story to all other providers
  - PPs helps the MH act accurately in lieu of themselves – **effusive communication**
  - Active patient sign-outs – written and verbal, not just “postings”
  - *EHR and Care Plan notes which present the patient, not just their diagnoses
  - Available (in person or by proxy) to other providers for real-time communication if desired: e.g. ER Docs, Hospitalists, Consultants, Community providers

Implementing the Medical Home
Definitions – MAFP – Core Principles

- Care Coordination
- The Personal Physician*
- **Focus on Quality and Safety**
- Patient-Centeredness
- Enhanced Access
- Comprehensive Care
- (Compensation Reform)

Idealized MH
- Quality and Safety -

- Disease Management:
  - Disease Registries for Common Conditions
    - Searchable and Electronic
    - Track QI Benchmarks / Analyze Practice Results
  - Reference EBM Guidelines – can build into care plans
  - Preventive care and benchmark reminders built into the Health Record for pt. notification
  - Routine Use of Care Plans
  - Decision Support Tools; Information Technology
    - Evidence guideline references, e.g. ICSI, IHI tools
    - Diagnostic test ordering
    - Med interaction, Prescribing info, Formulary interfaces
  - Clinic Support for Pt Self-Management – Dz, PHR

Idealized MH
- Quality and Safety -

- Community Boards – accountability to clientele
- Patient Surveys
- Well-established QI processes
  - QI markers are identified and tracked
    - Specific disease benchmarks
    - Other indicators: e.g. hospital readmissions, patient deaths, abnormal lab results, patient complaints, preterm births, NICU admissions, etc.
  - Include patients in review and recommendation committees
- Transparent Performance Reporting

Idealized MH
- Quality and Safety -

- Redundant considerations impacting quality and safety:
  - A culture of continuity-based care
  - EHR excellence:
    - accuracy, relevance, currency
  - Patient-Centeredness mechanisms
  - Care Coordination
  - "Seamless Care"

Implementing the Medical Home
Core Principles

- Care Coordination
- The Personal Physician
- Focus on Quality and Safety
- **Patient-Centeredness** – more than "all we do is for patients"
- Enhanced Access
- Comprehensive Care
- (Compensation Reform)

Idealized MH
- Patient Centeredness -

- Patient needs / preferences are guiding concepts
- Culture of service, communication, empowerment
- Incorporation of patients into care teams
- Structure systems which allow for individualization of care decisions
- Structure systems which connect patients w/ the providers who know them
- Ensure adherence to other guiding principles of MH *– care coordination, enhanced access, a focus on quality and safety, connection with personal physicians, comprehensive care access*

Idealized MH
- Patient Centeredness -

- Patient and Family Empowerment:
  - Partners on Care Team; Sign on to Care Plans
  - Connected to Personal Physicians / Care Coordinators
  - Built into QI processes/committees
  - Built into Community Clinic advisory boards
  - Partner participants in Learning Collaborative
  - Participate in disease self-management
  - Participate in scheduling and record-keeping processes
    - Computer access for health record summary review
    - Appt.scheduling access by computer in some form
  - Carry and transmit Care Plans to other providers

Idealized MH
- Patient Centeredness –

- Preference-Sensitive Care
  - Acknowledgement of evidence that patients really do make relevant, cost-effective care choices when adequate educational time is spent with them regarding decisions, and when then empowered to do so.
  - Helps clinicians avoid "Gate-keeping", and to become a "Gateway" instead
  - Achieves care in the context of patient needs, values, circumstances

Idealized MH
- Patient Centeredness -

- Office Redesign:
  - Waiting Room space – clean, safe, allows for privacy, but promotes human interaction too
  - Kids' space – supervisable, sanitary, educational and 'healthy' toys
  - Construction Materials and techniques which promote health:
    - "Green" design / materials – non-toxics, low energy use
    - Warmth, light, space, sound control, traffic control
  - Patient Flow – smooth whole-clinic function

Idealized MH
- Patient Centeredness -

- Office Redesign (cont.):
  - Computer Access to Interactive clinic website:
    - Scheduling; Clinic Feedback
    - Caregiver Communication
    - Health Record summary review; office visit intake; test results review
    - Health education resources
    - Clinic QI performance viewing; Fee structure reference

    - Creates transparencies, encourages communication and MH participation

Idealized MH
- Patient Centeredness -

- Enhanced Office Processes:
  - Billing and payment assistance, and insurance statement interpretation
  - Well-established processes for reliable, timely, understandable test results, recommendations, and referral info transmission to patients
  - Enhanced access to clinic by patients – in person, and remotely
- Patient Education:
  - Intentionally structured part of every visit
  - Use of trained patient educators… along with other team clinicians and care coordinators
  - Self-Education tools, Group education formats

Idealized MH
- Patient Centeredness -

- Sensitivity to Special Needs:
  - (Beyond wheelchair access…)
  - Social Services access
  - Interpreter access – deaf or non-English languages
  - Plans for addressing transportation needs
  - Medications access:
    - Meds assistance program entry
    - Pharmacy delivery services
    - Prescription faxing
  - Allied provider access – therapists, counselors, clinical nurse specialists, dieticians
  - Home Visits

Implementing the Medical Home
Core Principles

- Care Coordination
- The Personal Physician
- Focus on Quality and Safety
- Patient-Centeredness
- **Enhanced Access** – not just to doctor/providers, but all elements of practice
- Comprehensive Care
- (Compensation Reform)

Idealized MH
- Enhanced Access -

- Electronic Scheduling systems
- Electronic Billing Services interaction
- E-Communication w/ Care Team
  - HIPAA Compliance; Triage protocols; Monitored
  - Care team member access to well-kept health record
- E-Visits
- Group Visits
- Walk-in care / Open Access / Advanced Access systems of scheduling – (continuity)
- Extended Hours for "Convenience Care"

Idealized MH
- Enhanced Access -

- 24/7 Acute Care access plan that isn't solely "Go to E.R."
  - Implies On-call system
  - Intermediary triage systems
  - Records access by proxy covering physicians
  - Care Plan maintenance and portability
- Resources for remote patient access to clinic and team caregivers:
  - Telephone, Computer
  - Clear clinic policies; client feedback review policies
  - Avoidance of "Waiting Times" – "on hold" /return message pending

Idealized MH
- Enhanced Access -

- Remote other-care-giver access to clinic care team members and personal physicians (and proxies):
  - NH, ER, Hospitalists, Consultants, Community service providers
- Transportation / Interpreter services access

Implementing the Medical Home
Core Principles

- Care Coordination
- The Personal Physician
- Focus on Quality and Safety
- Patient-Centeredness
- Enhanced Access
- **Comprehensive Care**
- (Compensation Reform)

Idealized MH
- Comprehensive Care -

- Part of what was referenced by 'Basket of Services' term from FFM
  - Not "Full One-Stop Shopping", but *multiple services under one roof*, through care team members
    - E.g. Personal physician, Diabetes education, dietary counseling, social work appts, PT, mental health counseling, foot care…

Idealized MH
- Comprehensive Care -

- Comprehensive and Integrated Access to:
  - preventive care, acute care, after-hours care, NH and assisted living care, Subspecialist consultation, hospital and emergency care, hospice services, social and community services…

    …Either through the primary clinic, OR through facilitated and coordinated access to all levels of service via communication and consultative arrangement between primary care clinic and other settings.
  - *Implies an **active communication** relationship – and **mutual access** – between personal physicians, other care team members, and providers in other settings.*

(cont)

Idealized MH
- Comprehensive Care -

- hospitals, subspecialists, and community providers in a well-formulated Medical Home network support the primary care clinic (and patients' personal physicians) as the center of communication that coordinates and integrates all care for patients.
- Evidence says this coordinated comprehensiveness creates quality, value, trust
- We have to work to re-secure this level of respect and cooperation from those care partners, and to re-secure this type of coordinated, comprehensive care for patients.

Implementing the Medical Home
Core Principles

- Care Coordination
- The Personal Physician
- Focus on Quality and Safety
- Patient-Centeredness
- Enhanced Access
- Comprehensive Care
- **(Compensation Reform)**

Compensation Reform
Ideas on the Table

- Accentuated compensation rate – all codes – for clinics assessed/rated/certified/recognized to be performing as Medical Homes
- Flat Rate Reimbursement: Per-member-per-month payments for each life "covered" by a functioning medical home.
- *Care Coordination fees for public patients with complex care needs – **DHS** - $/member/month
- Complexity management codes & modifiers
- Total cost-of-care bid reimbursements
- All imply need for assessment of performance, for "Medical Home Designation"

Implementing the Medical Home
- First Steps -

- Review and Reference:
  - Joint Principles/MAFP **Core Principles** of Medical Home – use 'em all
  - AAFP/IHI Key Concepts for Chronic Dz management
  - **NCQA Key measures for MH Recognition**
  - MN-DHS Care Coodination Tools
- Build Infrastructure:
  - Put in **disease registries** – common conditions
  - Catalogue references; nationally endorsed measures
  - Employ data management technology

Implementing the Medical Home
- First Steps -

- Build Resources:
  - **care plans**
  - **care coodinators**
- Build relationships:
  - Connections to **community resources**
  - **Partner** with other care settings/providers
- Build Policy
  - Renew **communication** policies which inform all care team partners about patients – ensure "continuuity"
  - Construct **QI system**

Implementing the Medical Home
- First Steps -

- Build Resources:
  - **care plans**
  - **care coodinators**
- Build relationships:
  - Connections to **community resources**
  - **Partner** with other care settings/providers
- Build Policy
  - Renew **communication** policies which inform all care team partners about patients – ensure "continuuity"
  - Construct **QI system**

Implementing the Medical Home

Reference Definitions – (AAFP/AAP/ACP/AOA)

- The Joint Principles of a Patient-Centered Medical Home:
  - Personal Physician – longitudinal relationships
  - Physician-directed Practice – MD/DO/teams
  - Whole-person Orientation – comprehensiveness, holism
  - Care Coordination/Integration – across in-clinic care, and between all settings and resources
  - Quality & Safety
  - Enhanced Access
  - Payment Reform

Implementing the Medical Home

Reference Definitions – MAFP Core Principles

- Patient Centeredness
- Care Coordination
- The Personal Physician
- Enhanced Access
- Focus on Quality and Safety
- Comprehensive Care
- (Compensation Reform)

Implementing the Medical Home

Reference Definitions – AAFP/IHI Key Concepts

- Team Approach to Care
- Registries for the top few diagnoses
- Active Care Coordination
- Prospective data collection
- Clinical Information Systems
- Partnership with Community Resources
- Advanced Patient Education and Self-Management support

Implementing the Medical Home

Reference Definitions – NCQA Key Processes

- Access and Communication
- Patient Tracking and Registry Functions
- Care Management
- Pt. self-management support
- Electronic Prescribing
- Test Tracking
- Referral Tracking
- Performance Reporting and Improvement
- Advanced Electronic Communications