Setting Residents Up for Success in Practice

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Medical Home: History

- Concept introduced by American Academy of Pediatrics (AAP) in 1967
- In 2004, Future of Family Medicine (FFP) expanded the concept
- In 2006, ACP introduced its version, the "advanced medical home"
- In 2007, AAFP, ACP, AAP & AOA drafted joint principles on the Patient-Centered Medical Home (PCMH)

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Medical Home Principles

- 7 PCMH principles:
  1. Personal physician
  2. Physician directed medical practice
  3. Whole-person orientation
  4. Care is coordinated and/or integrated
  5. Quality and safety
  6. Enhanced access
  7. Payment

PCMH in a Nutshell

PRACTICE ORGANIZATION

- Financial Management
- Practice Development
- Practice Data
- Customer Engagement

HEALTH INFORMATION TECHNOLOGY

- E-prescribing
- Population Registry
- Clinical Decision Support Tools
- Connection
- Experimental Care Delivery

QUALITY MEASURES

- Registries
- Referrals
- Patient Safety Alerts
- Patient Reminders
- Care Plan

PATIENT EXPERIENCE

- Open/Advanced Access Scheduling
- Patient Portal
- Patient Self-Management
- Communication

Barbara Starfield Version:

- First contact care;
- Person-focused care over time;
- Comprehensiveness of care; and
- Care coordination

(Community orientation, cultural competence and family-centeredness all ultimately derive from the four features.)

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Already a Medical Home?

Commonwealth Survey of PCPs

- 60% say they do not have arrangements for patients' after-hours care.
- 28% of US PCPs have EMRs (vs. 89% in the UK)
- 29% use multi-disciplinary teams
- 37% regularly receive info back from referrals

PCMH & Subspecialty Care: ACP View

- PCMH should have systems to effectively communicate w/specialists and have efficient referral processes.
- PCMH may complete more preliminary patient evaluations for those they previously would have referred
  - This may mean a decrease in low complexity referrals; more complex referrals would have more robust documentation to improve the process.

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PCMH & Subspecialty Care *cont.*

When a sub/specialist provides ongoing **principal care** for a patient in the PCMH model:

- This physician would be responsible for routine first contact care (e.g., bronchitis, skin infections, urinary tract infections, routine preventive health measures).

- or -

- A **principal care** physician hires an NP for primary care.

- or -

- A **principal care** physician working in a multi-specialist practice can team-up with a primary care colleague.

PCMH: NCQA Definition

- NCQA definition of a medical home:
  - Each patient has an ongoing relationship with a personal physician who leads a team that takes collective responsibility for patient care.
  - The physician-led care team is responsible for providing all the patient's health care needs and, when needed, arranges for appropriate care with other qualified physicians

PCMH: NCQA *cont.*

- PPC-PCMH has 3 levels of recognition and measures in the following domains:
  - Access/communication
  - Patient tracking/registry functions
  - Care management
  - Patient self-management support
  - E-prescribing
  - Test/referral tracking
  - Performance reporting
  - "Advanced" electronic communication

PCMH: Challenges

- "Teaching" medical home-ness is a challenge
  - Many docs think they are already providing it
  - Belief comes from a positive place:
    - "I care about my patients"
    - "I work hard every day making sure my patients get the best care possible"
    - "I have great relationships with my patients"

So, what is a medical home?

- The lessons from quality improvement tell us that often physicians are surprised by their data and/or have come to accept current practice challenges:
  - "I thought all my patients were regularly getting their micro-albumin testing"
  - "I wish I could get ophtho results back when I refer my patients for an exam"
  - "I don't understand why [Blue Cross, Aetna, United, etc.] won't pay for a [foot exam, same-day E/M, consult . . .]

Concept, Activities, Workflow, Measure

- Continuity with PCP/team
  - My patients are consistently able to get an appointment with the same members of their care team when needed.
  - For patients that don't have insurance, I know resources and options.
- Same-day capacity
  - Patients are able to get an appointment on the day they need it.
- Telephone advice during office hours
  - When patients need advice, they can call my office and have questions answered either immediately or within an appropriate time period.
  - My office has a process to route patient questions to the appropriate person and make sure questions are answered.
- Telephone advice when office is closed
  - I have a system in place so that patients know where to go when they have urgent questions and the office is closed.

Concept, Activities, Workflow, Measure

- Interactive Web site (i.e., scheduling, medical history functionality)
  - My patient's can schedule appointments over the phone, through our Web site, or via a call center. This frees up my staff's time and makes it convenient for my patient.
  - Patients can enter medical history information via a secure connection. This saves time during the clinical encounter.

Concept, Activities, Workflow, Measure

- Consultation with appropriate providers (e.g., nutritionist, subspecialist)
  - I have a team of experts, either internal or external to my practice, to whom I can refer patients.
  - We have an agreed upon mechanism so that I can ensure my patient records are up to date and I can help my patient navigate "the system".
  - I know my patient panel, particularly those with chronic diseases, and know the community resources that will be of assistance (e.g., support groups for patients with diabetes).

Concept, Activities, Workflow, Measure

- Written policies and procedures
  - I know what my office policies are.
  - My staff know what the office policies are.
  - I have a process to involve staff in making improvements to policies and procedures.
  - New staff are appropriately trained and there is available documentation of office policies to support them.
- Language services
  - When patients who prefer to receive health services in another language make an appointment, I have systems to track this.
  - I know how to access interpreter services.

Concept, Activities, Workflow, Measure

- Patient-Provider Email
  - I have policies and systems for secure patient-provider email.
  - My patients know what these policies are (i.e., they know what situations are appropriate for email and how long it will take me to respond).
- Measurement
  - In addition to clinical outcomes and measures, I know tools and processes to analyze patient cycle time, patient experience, staff satisfaction, etc.
  - I regularly involve my staff in these analyses and we have a process in place to systematically and inclusively address problems.

In summary, can a physician say:

1. I know who my patients are (i.e., patients that are part of my panel and for whose care I am responsible).
2. My patients are satisfied that they can get the kind of care they need when they need it.
3. My office systems are structured so that non-value added steps are minimal and there is a logical flow for information (e.g., patient messages, refill requests). This means I, or other members of the care team, can spend more time in the clinical encounter and/or manage patients via email and telephone.
4. I regularly measure clinical and process measures. My beliefs about the kind of care I provide are based on sound, relevant data.

Medical Home Resources (selected)

- The Medical Home, Access to Care, and Insurance: A Review of the Evidence (*Pediatrics* 2004; 113; 1493 – 1498)
- The Medical Home: An Idea Whose Time Has Come . . . Again (*Family Practice Management*, Sept. 2007)
- The Patient Centered Medical Home: History, Seven Core Features, Evidence and Transformational Change (Robert Graham Center, November 2007)
- Making Medical Homes Work: Moving from Concept to Practice (Center for Studying Health Systems Change, December 2008)
- Achieving a patient-centered medical home as determined by the NCQA—at what cost and to what purpose? (Annals of Family Medicine, Jan/Feb 2009)

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