Forum Session
Meeting Announcement

Tuesday, October 28, 2008
11:45am–12:15pm — Lunch
12:15–2:15pm — Session

Building the Medical Home: Surveying the Floor Plans

A Discussion Featuring:

Don Klitgaard, MD
Medical Director
Myrtue Medical Center

Paul Kaye, MD
Medical Director
Hudson River HealthCare

Don Liss, MD
Mid-Atlantic Medical Director
Aetna

Kim Davis-Allen
Director
Medical Services Division
Project Manager
Together for Quality
Alabama Medicaid Agency

Location

Reserve Officers Association of the United States
One Constitution Avenue, NE
Congressional Hall of Honor
Fifth Floor
(Across from the Dirksen Senate Office Building)

Registration Required

Space is limited. Please respond as soon as possible.

Send your contact information by e-mail to: **nhpfmeet@gwu.edu**

Building the Medical Home: Surveying the Floor Plans

OVERVIEW

The medical home model continues to attract support among health plans, employers, providers, and policymakers. Numerous demonstrations are contemplated or already under way. The second in a series looking at the medical home concept, this Forum session will present a sampler of medical home "floor plans." Organizations represented include a rural physician practice, a federally qualified health center (FQHC), a large health insurer, and a state Medicaid plan. Each has undertaken practice redesign and culture change in order to create medical homes for patients.

SESSION

Not surprisingly, the idea of a medical home where a person can be sure of receiving patient-centered, well-coordinated care has found a broad array of supporters. It makes so much sense, and sounds so cozy. But a medical home is not like the old Sears houses, available out of a catalog for ready assembly. Any entity contemplating becoming, sponsoring, or paying for a medical home must make decisions about its design components and how they should fit together.

The medical home model has been promoted as the solution to a variety of problems, from a shortage of primary care physicians to the disproportionate cost burden associated with multiple chronic illnesses to the frustration and confusion of trying to navigate a complex health care system (especially when very sick). As envisioned by proponents, the medical home is a physician-directed practice that delivers care that is "accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective."[1] In other words, it is a brand of care that comparatively few existing practices are equipped to deliver.

Dr. Robert Berenson and colleagues suggest that medical home advocates have different though not inconsistent expectations and emphases: "For some, the concept relates mostly to the 'patient-centered' component; for others, the most salient characteristics are found in improving the 'systemness' of care, aided by new health information technology and organizational structures; while still others emphasize chronic care management."[2]

One conviction that unites advocates is that some type of payment system reform will be required to make primary care function more effectively. Most often mentioned is moving away from an emphasis on paying for procedures and toward paying for communication and counseling. Some observers have cautioned that channeling more money to primary care physicians will not occur without protest from specialists.

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2131 K Street NW, Suite 500
Washington DC 20037

202/872-1390
202/862-9837 [fax]
nhpf@gwu.edu [e-mail]
www.nhpf.org [web]

Judith Miller Jones
Director

Sally Coberly, PhD
Deputy Director

Monique Martineau
Publications Director

Forum Session Manager
Lisa Sprague
Principal Policy Analyst

Not waiting for payment reform, the National Committee for Quality Assurance (NCQA) has developed a medical home recognition program based on the medical home principles jointly developed by the primary care specialty societies and emphasizing the use of "systematic, patient-centered, coordinated care management processes."[3] Applicants are assessed on nine standards, which can lead to one of three levels of recognition. This voluntary recognition program has been endorsed by the Patient-Centered Primary Care Collaborative (PCPCC), a broad-based coalition of employers, insurers, and provider and consumer groups.

While the ideal design will continue to be debated, various demonstration projects are in development or already under way. The PCPCC is monitoring multiple-purchaser medical home initiatives operating in 16 states. A Medicare demonstration project, required by the Tax Relief and Health Care Act of 2006, is in the design stage. States, localities, health plans, and physician groups have implemented elements of a medical home model; how these mesh and drive practice depends in large part on organizational characteristics. Practice transformation is bound to be different in, say, a Geisinger Health System—which owns a health plan, has ten years' experience with electronic health records, and employs clinical staff in a market it dominates—from that in a two-physician practice just beginning to venture into health information technology.

This Forum session builds on discussion at a June 2008 meeting about the medical home concept. (For more information and slides from the presentations, see www.nhpf.org/index.cfm?fuseaction=Details&key=698.) The purpose of this session is to present a sampler of organizations that have adopted and adapted the medical home model to meet their own goals. They are:

- **Myrtue Medical Center —** This eight-physician primary care practice, comprising four clinics in Harlan, Iowa, was one of 36 pilot sites in the American Academy of Family Practice's TransforMED initiative. TransforMED was a 24-month national demonstration project launched in June 2006, designed to test an integrated set of best practices aimed at "transformational redesign of both the work and the workplaces of family and primary practices in order to better serve the changing needs of patients, physicians, and practice teams."[4] Among the changes the Iowa group adopted were open-access scheduling, an electronic health record (EHR) system, and regular patient satisfaction surveys. Chronic disease management is the focus going forward.
- **Hudson River HealthCare (HRHC) —** This federally qualified health center (FQHC) delivers care in 13 clinic sites in a nine-county region of upstate New York. It was a participant in the quality-oriented Health Disparities Collaborative sponsored by the Health Resources and Services Administration and continues to be active in successor collaboratives focused on prevention and disease management. Believing that it already embodies many of the sought-for characteristics, HRHC

is pursuing certification by the NCQA as a patient-centered medical home. Team-based care is strongly emphasized, with staff designated as "patient care partners" to serve as case managers and provide support and system navigation assistance to patients.

- **Southeastern Pennsylvania's Chronic Care Initiative —** The Governor's Office of Health Reform established by Gov. Edward G. Rendell has proposed a comprehensive reform initiative designed to address access, affordability, and quality in health care. Elements implemented to date include expanded access to insurance for children, mandatory reporting of health care–associated infections, and expanded scope of practice laws for health care professionals. A statewide chronic care initiative which encompasses a medical home model is being rolled out regionally, beginning in the Philadelphia area. Multiple insurance carriers, including Independence Blue Cross, Aetna, and the three Medicaid managed care plans, will significantly enhance payment to 31 practices for participating in a learning collaborative, establishing patient registries, and achieving NCQA designation as a patient-centered medical home.

- **Alabama Medicaid —** Alabama used a traditional 1915(b) Medicaid waiver to establish a primary care case management (PCCM) program in 1997. Renamed "Patient 1st," the program was revamped in 2004 to add various per-member per-month case management fees (for example, $0.85 for offering 24/7 office coverage), e-prescribing, and performance and efficiency measures with a portion of savings shared between the state and the physician practice. In addition, in 2008, the Medicaid agency, leading a group of public and private partners, was awarded a federal transformation grant (under the Deficit Reduction Act of 2005). Under the title "Together for Quality," the plan is to use the $7.6 million to create a statewide electronic health information system linking Medicaid, state health agencies, providers, and private payers that will support a comprehensive quality improvement model for the Alabama Medicaid program.

KEY QUESTIONS

- How does the medical home model differ from existing standards of good primary care? Aren't all primary care clinicians already trying to provide this kind of care?

- How does the medical home relate to other parts of the health care system? What incentives do specialists have to cooperate in care coordination efforts? How do medical homes manage or coordinate their patients' hospital care?

- Is participation in a medical home voluntary for patients? What is expected of them as part of a medical home? What if a patient in a medical home loses his or her insurance coverage?

- Does the medical home model have the potential to reduce the income disparity between primary care and specialty physicians?
- How should medical home practices be held accountable to patients, payers, and their local populations?
- What practice characteristics are most conducive to establishing a medical home? How can practice transformation be measured?
- What action by government or private sector stakeholders would encourage the medical home model to proliferate?

SPEAKERS

Don Klitgaard, MD, FAAFP, is the medical director of the Myrtue Medical Center clinics in Harlan, Iowa, where he has been the physician champion of the practice's participation in the TransforMED National Demonstration Project. He will talk about how the practice is actively evolving into a patient-centered medical home. **Paul Kaye, MD**, pediatrician and medical director of Hudson River HealthCare, will discuss the role of the community health center as a medical home and how HRHC has pursued Joint Commission and NCQA recognition. **Don Liss, MD**, a regional medical director for Aetna, will describe the medical home component of the Prescription for Pennsylvania, progress to date, and his firm's rationale for being involved. **Kim Davis-Allen**, project manager for Alabama's "Together for Quality" initiative and director of the Medicaid agency's Medical Services Division, will describe the various strands of the state's medical home network.

ENDNOTES

1. American Academy of Family Practice, American Academy of Pediatrics, American College of Physicians, and American Osteopathic Association, "Joint Principles of the Patient-Centered Medical Home," March 2007, p. 3; available at www.medicalhomeinfo.org/Joint%20 Statement.pdf.

2. Robert A. Berenson *et al*., "A House is Not a Home: Keeping Patients at the Center of Practice Redesign," *Health Affairs,* 27, no. 5 (September/October 2008): p. 1220.

3. National Committee for Quality Assurance, "Physician Practice Connections–Patient-Centered Medical Home"; available at www.ncqa.org/tabid/631/Default.aspx.

4. TransforMED, "The New Model"; available at www.transformed.com/newModel.cfm.

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