Transforming Care – the Medical Home and the Health Home Models

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Disclosure

- I have no financial interests to disclose in relation to the material that I am presenting today.

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Confusing labels…

- Medical Home ≠ Health Home
  - Well, not usually – but sometimes it can
  - Or, when you're in Minnesota or Oregon

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Health Home – according to ACA 2703

- Delivers a defined set of six services
- To Medicaid beneficiaries with specific chronic health or mental health conditions; or dually eligible individuals
- By a designated provider, team of health professionals, or health team
- Could be provided by a primary care medical home, but may involve a larger team or a non-traditional health care setting

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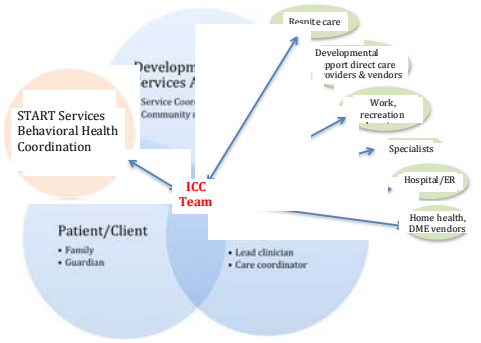
Proposed NH CareConnect Health Home Model for Dually-eligible Adults

Figure 2 CareConnect – Integrated Care Coordination Model



Medical Home

- Brand name for primary care
- CMHI defines the medical home as a **community-based primary care setting** which provides and **coordinates high quality, planned**, **family-centered** health promotion, acute illness care, and chronic condition management — across the lifespan. Care in a medical home is rewarding for clinical teams to provide and satisfying for patients and families to receive.

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Why rebrand primary care?

- Ratio of primary to specialty care providers
  - US = 30/70
  - Other industrialized nations = 70/30
- Communities in the US with higher concentrations of primary care
  - Lower costs
  - Better population health outcomes
- Decade long decline in career interest in primary care for US physicians in training

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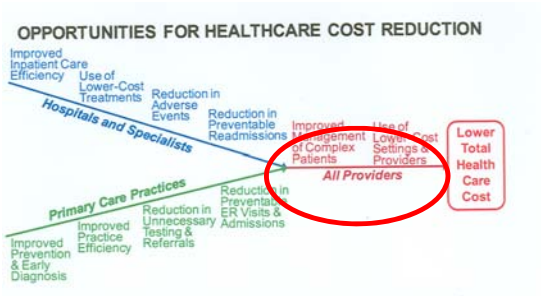
Lowering health care costs - an urgent priority



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Integrated care organizations including accountable care organizations (ACO)

- Provider-led organizations with strong base of primary care
- Collectively accountable for quality and costs across the full continuum of care for a population of patients
- Payments linked to quality improvements
- Reliable and progressively more sophisticated performance measurement to provide confidence that savings are achieved through improvements in care.[5]

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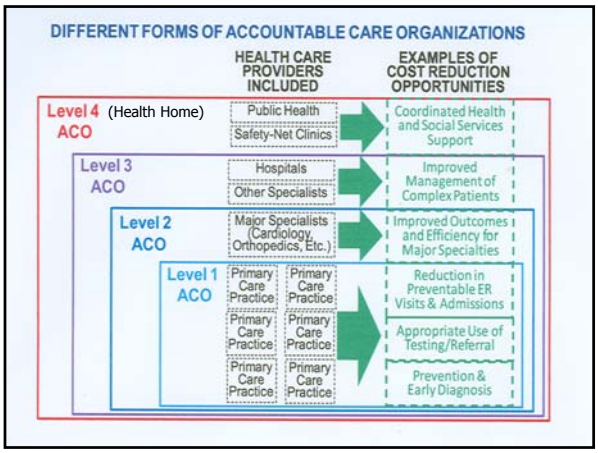

ACOs may make Medical Home brand irrelevant

- Primary care settings without medical home functionalities will not be able to survive in an ACO environment
  - Even with medical home recognition awards

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Necessary Medical Home functionalities

- Empanelment – relationship with patients and families
- Access – evening, weekends, holidays, same day
- Proactive, health promotion
- Co-management with specialists – explicit, clear
- Coordination of care and services
  - Vertically and horizontally
- Management of transitions in care
- Integrated, high quality information systems
- Family engagement in care and improvement

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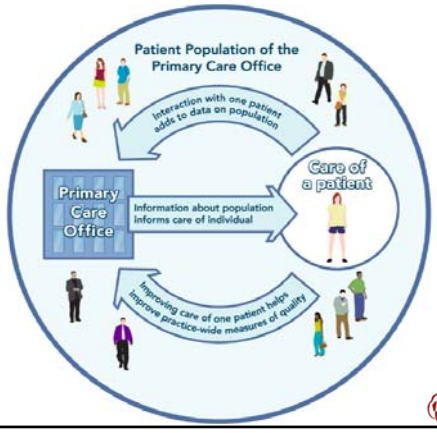
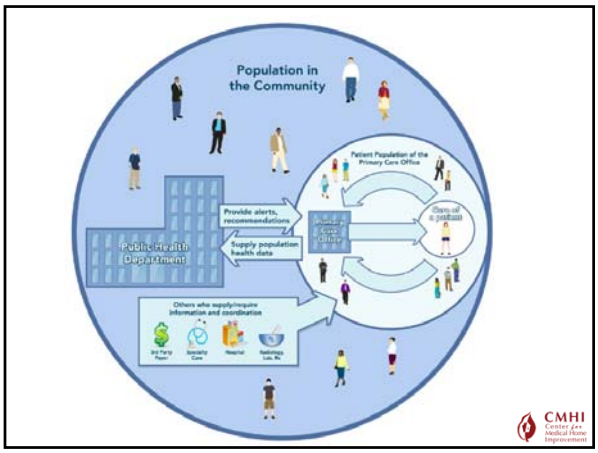
Medical Home – the interface between personal health and public health

PBPH – Practice-Based Population Health

The Agency for Health Quality Research (AHRQ) defines practice-based population health (PBPH) "as an approach to care that uses information on a group ("population") of patients within a primary care practice to improve the care and clinical outcomes of patients within the practice. PBPH changes the focus from reacting to the ad hoc needs of individual patients to proactive management of a practice's patient panel."

*Practice-based population health: information technology to support transformation to proactive primary care
AHRQ publication no. 10-0092-EF, July 2010





Title V programs and medical home

- Close ties with provider organizations
- Close ties with Medicaid and private payers
- Culture of quality improvement
- Data links between public health and primary care
- Track the population of CYSHCN
  - ❑ Satisfaction with care they receive
  - ❑ Health outcomes – health status of the popuulation
  - ❑ Cost of their care
- Inform staff and families about using the "new" health care system effectively

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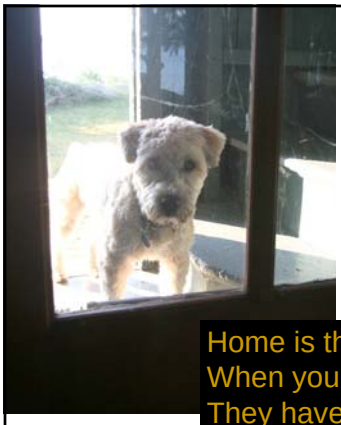

Home is the place where
When you have to go there
They have to take you in