



IT Support for Medical Home

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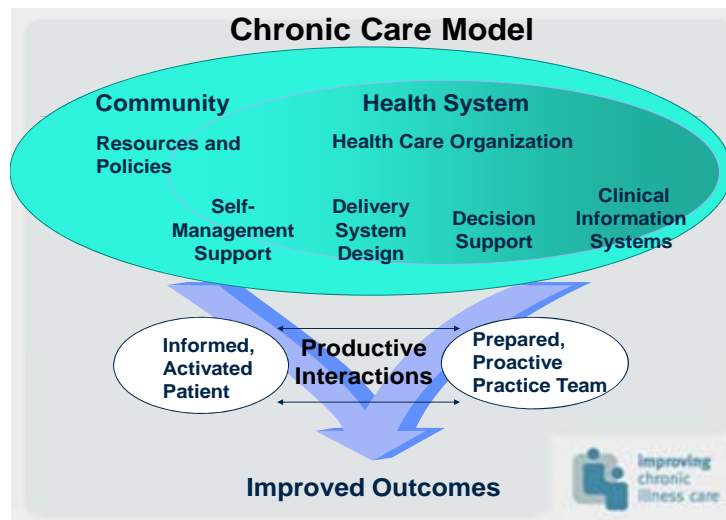
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Medical Home 101

Era of Transparency & Accountability

- Development of evidence based medicine
- Define and standardize clinical metrics
- Convergence around new measures
- Awareness of effectiveness
- Industry shifts in practice
- Changes in reimbursement
- *Value Driven Health Care*





What is Medical Home?

- Originally introduced in 1967 by the American Academy of Pediatrics (AAP)
- Focused on the care of children with special needs
- Refers to a central location for storing a child's medical record for better coordination of care
- In 2002 the AAP expanded the definition of a Medical Home as a model of delivering primary care that is:
 - Accessible
 - Coordinated
 - Continuous
 - Compassionate
 - Comprehensive
 - Culturally Effective
 - Family-Centered



What is Medical Home?

March 2007 the Joint Principles of the patient-centered medical home (PCMH) were established and endorsed by:

- American Academy of Pediatrics
- American Academy of Family Physicians
- American College of Physicians
- American Osteopathic Association

13 specialty healthcare organizations have also since endorsed the joint principles.

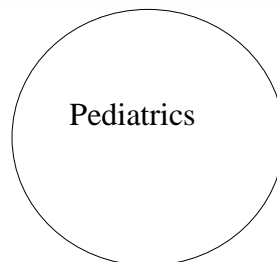
The Joint Principles of the PCMH are based on two conceptual frameworks:

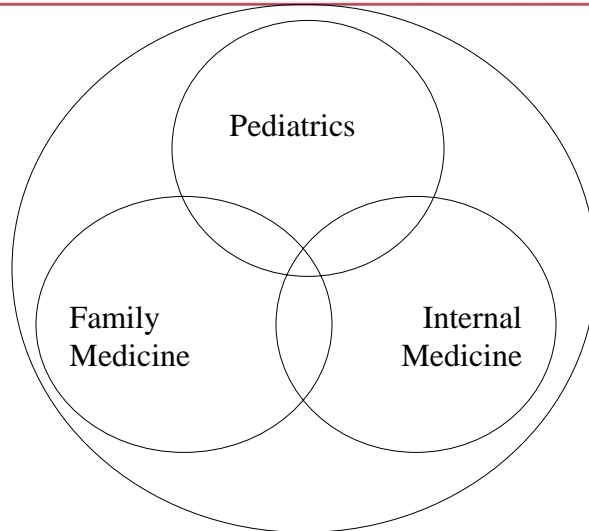
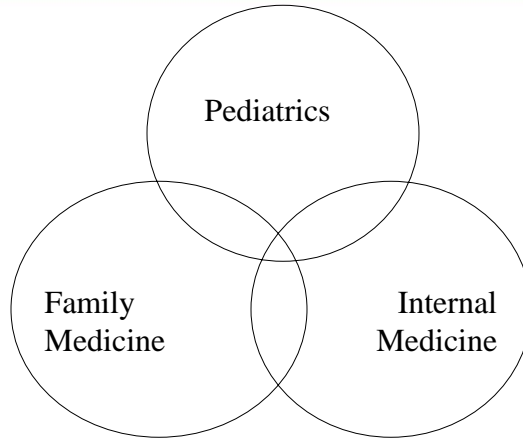
Primary Care Model

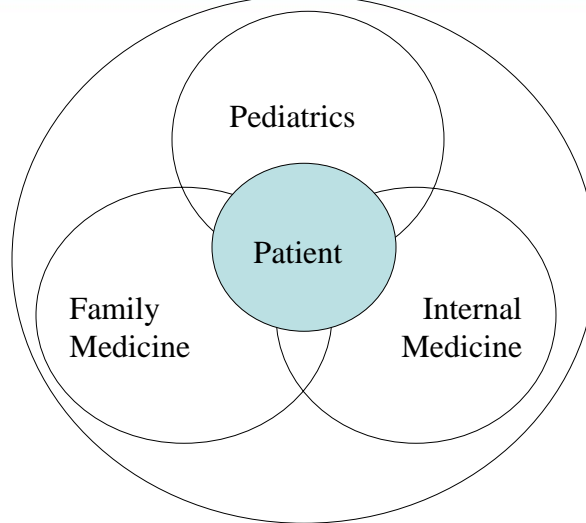
- Accessible
- Continuous
- Coordinated
- Comprehensive

Chronic Care Model

- Patient Self Management Support
- Clinical Information Systems
- Delivery System Redesign
- Decision Support
- Health care Organization
- Community Resources







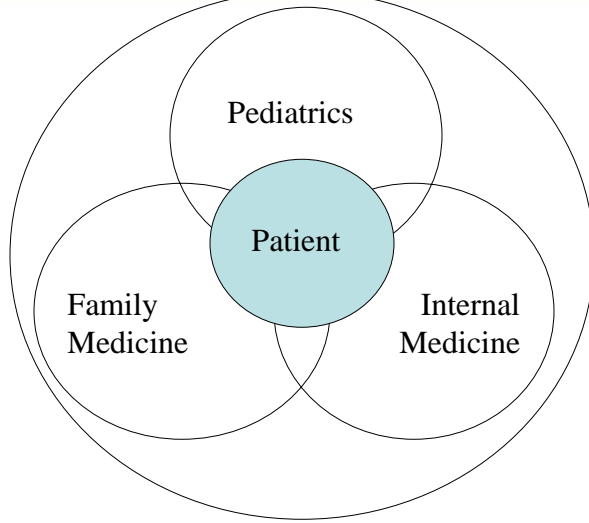
The Joint Principles define seven key characteristics of the PCMH:

- Personal physician
- Physician directed medical practice
- Whole person orientation
- Coordinated or integrated care across the system
- Quality and Safety
- Access
- Payment



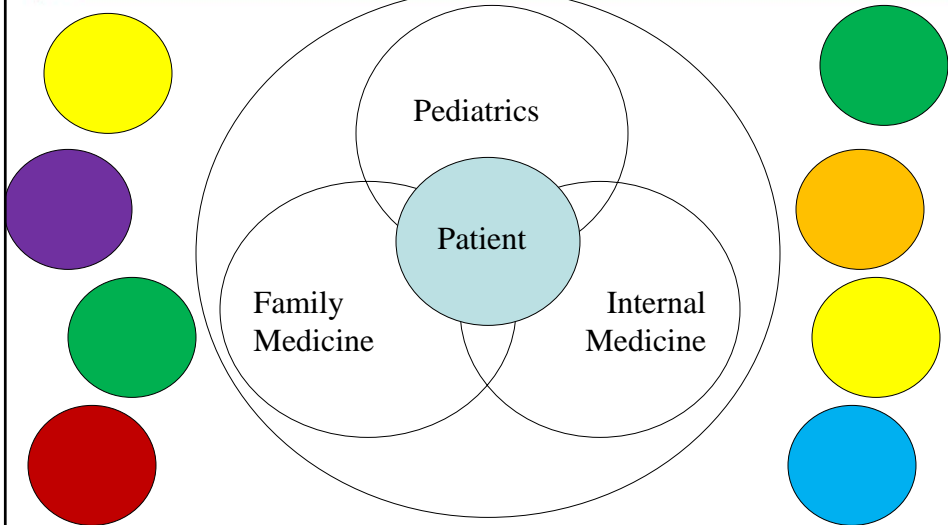
Iowa Healthcare Collaborative

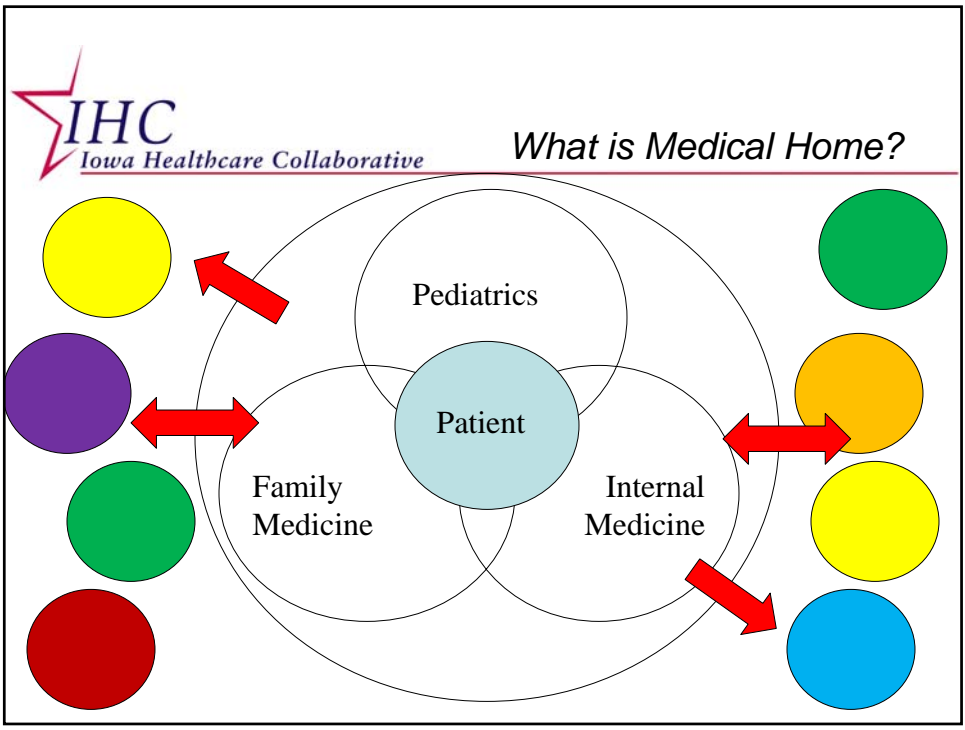
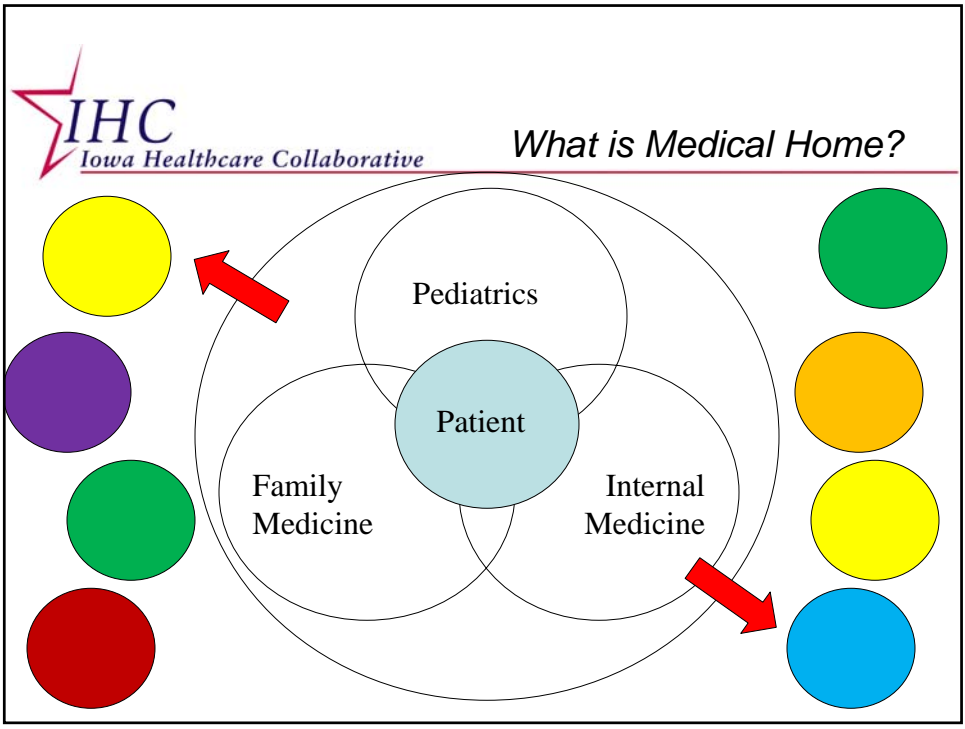
What is Medical Home?



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What is Medical Home?

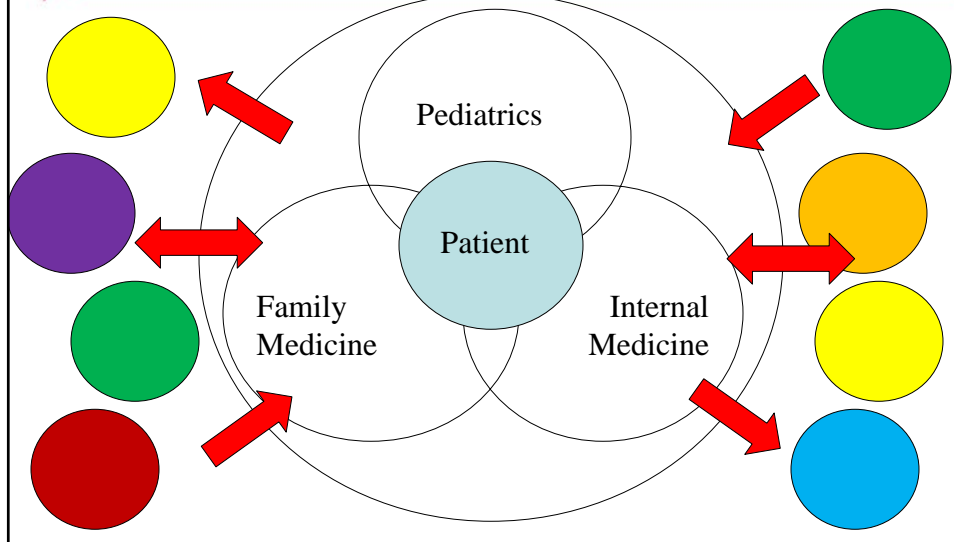






Iowa Healthcare Collaborative

What is Medical Home?



Iowa Healthcare Collaborative

Is This New?

How is the PCMH model of care different than current primary care?

- "Primary care on steroids" - Raises the bar
- New responsibilities and capabilities
 - *Population-based medicine*
 - *Electronic Health Record*
 - *Measuring and reporting data to improve care*
 - *Open access scheduling*
 - *Referral and test tracking*
 - *Partnerships with community resources*

Medical Home Learning Community

Medical Home Learning Community

- Iowa Academy of Family Physicians
- HF 2539
- IHC 2008 Ambulatory Learning Community
 - *Pre-Medical Home curriculum*
 - *Equip practices- teams, registries and data*
- CMS Demonstration Project
- IAFP and IHC began to explore how to position Iowa for success... **Established Medical Home Work Group in July of 2008**



Medical Home Learning Community

1. Create a movement within the provider community
2. Develop a Learning Community
 - *Align and equip practices toward NCQA*
 - *Promote the Chronic Care Model*
 - *Participate in the national discussion*
3. Explore reimbursement redesign in Iowa to sustain PCMH model



Medical Home Learning Community Objectives

1. Initial practice assessment - *TransforMed*
2. Deploy the PCMH culture and techniques
3. Build a project plan and actively participate
4. Progress toward NCQA certification
5. Collect and submit data on an identified population of the practice using selected measure set

Medical Home...how do you know one when you see one?

- National Committee on Quality Assurance (NCQA)
- Nationally recognized 'measuring stick'
- Established criteria and assessment process to determine if physician practices are functioning as medical homes
- Criteria for reimbursement

Nine PPC-PCMH Standards:

1. Access and Communication
2. Patient Tracking and Registry Functions
3. Care Management
4. Patient Self-Management Support
5. Electronic Prescribing
6. Test Tracking
7. Referral Tracking
8. Performance Reporting and Improvement
9. Advanced Electronic Communications



2009 MHLC Schedule

- Pre-phase: Transformed Survey
- LS 1- 4/1/09:
- LS 2- 6/17/09
- LS 3- 9/9/09
- Next Steps...in development
 - *Content ties to annual conferences*
 - *Full year - ongoing cycles*



Who's in the Room?

- Over 160 attendees
- 36 clinical primary care teams
- Home health care
- Residents and teaching facilities
- Large health systems
- Independent physicians
- Many other interested parties



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All Teach All Learn

- Multiple perspectives on a common goal
- Community applications
- Series of panel-like discussions
- *“Keeping everyone open to sharing is going to be the success point of this project. If we all work together, then we have something very unique in the entire country. We’re working together instead of working just as individuals.” - MHLIC Participant*



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What now?

- Healthcare Reform is here to stay
- Medical Home is about transformation of Primary Care
- The model applies well to Iowa
- Population-based care is key:
 - first information management, then access and execution

The Joint Principles define seven key characteristics of the PCMH:

- Personal physician
- Physician directed medical practice
- Whole person orientation
- Coordinated or integrated care across the system
- Quality and Safety
- Access
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“If you don’t have a registry, you don’t know what you’re doing.”

- Dr. Joe Scherger
- Dr. Howard Beckman