Medical Home for Seniors and Other Persons with Complex Health Conditions

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"Healthcare" System

- What we have in the US isn't a system and it isn't even about healthcare – it is focused on <u>illness</u> care
- The work that is done in the medical system is focused on finding and treating (and sometimes on trying to prevent) disease.

What is "health"

 According to the World Health Organization:

> Health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity

 Who gets to define what "health" means for an individual? The WHO? Medicare? Insurance industry?

What is "health"

The individual decides!

Patient Centered Medical Home

Is this the answer?

What is a Medical Home?



Medical Home

NCQA definition:

The Patient Centered Medical Home is a health care setting that facilitates <u>partnerships</u> between <u>individual patients</u>, and their personal physicians, and when appropriate, the patient's family. Care is facilitated by <u>registries</u>, <u>information technology</u>, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a <u>culturally and linguistically appropriate</u> manner

Joint Principles of the Patient-Centered Medical Home

- American Academy of Family Physicians (AAFP)
- American Academy of Pediatrics (AAP)
- American College of Physicians (ACP)
- American Osteopathic Association (AOA)
- Personal physician each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care.
- Physician directed medical practice the personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.

Joint Principles of the Patient-Centered Medical Home

- Whole person orientation the personal physician is responsible for providing for all the patient's health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life; acute care; chronic care; preventive services; and end of life care.
- Care is coordinated and/or integrated across all elements of the complex health care system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient's community (e.g., family, public and private community-based services). Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.

Joint Principles of the Patient-Centered Medical Home

- Quality and safety are hallmarks of the medical home
- Enhanced access to care is available through systems such as open scheduling, expanded hours and new options for communication between patients, their personal physician, and practice staff.
- Payment appropriately recognizes the added value provided to patients who have a patient-centered medical home. The payment structure should be based on the following framework:

Medical Home at MCPN

- We strive to help individuals achieve the health they need to accomplish what is important to them in life.
- We recognize that an individual's view of what health means may be different than our vision
- We educate individuals on what we think should be done to achieve and maintain health, but the individual gets to decide.
- The "healthcare system" asks <u>"what is the matter with</u> you" and tried to help
- At MCPN we ask <u>"what matters to you"</u> and we build a health care plan based on that.

Medical Home at MCPN

- Each patient is a member of a health care team consisting of a medical provider and a medical assistant, along with others as needed. We strive to ensure that all care is handled by the patient's team.
- The team strives to understand what is important to each individual and build a plan for health based on that
- We plan for office visits
- We track outcomes

Medical Home at MCPN

- The team is in touch with the individual as needed in between office visits
 - We want to know what barriers to health the patient is experiencing
 - We try to ensure that when the patient is in another system of care (specialists office, ER, hospital, etc.) we know about it and can help with information sharing and help the individual understand what happened in the outside setting

Medical Home at MCPN Potomac Street Health Center model

- We had grant funding to provide an enhanced model of care for our most complex patients – that is those who
 - Take >10 prescription medications
 - See more than 1 specialist on a regular basis
 - Need assistance with ADLs
 - Have more than 2 ER or hospital visits in a year
 - Have mental illness, dementia or other cognitive disability
 - Have unstable housing
- Staffing
 - 2.0 FTE physician, 2.5 FTE nurse practitioner or physicians assistant
 - 3.0 FTE clinical care coordinator, 1.0 FTE health educator, 1.0 FTE behavior health specialist

Potomac Street Health Center model

- In our office we strive to overcome barriers to access including those caused by:
 - Architecture the "built environment"



Clinic entrance with ramp and push button opener

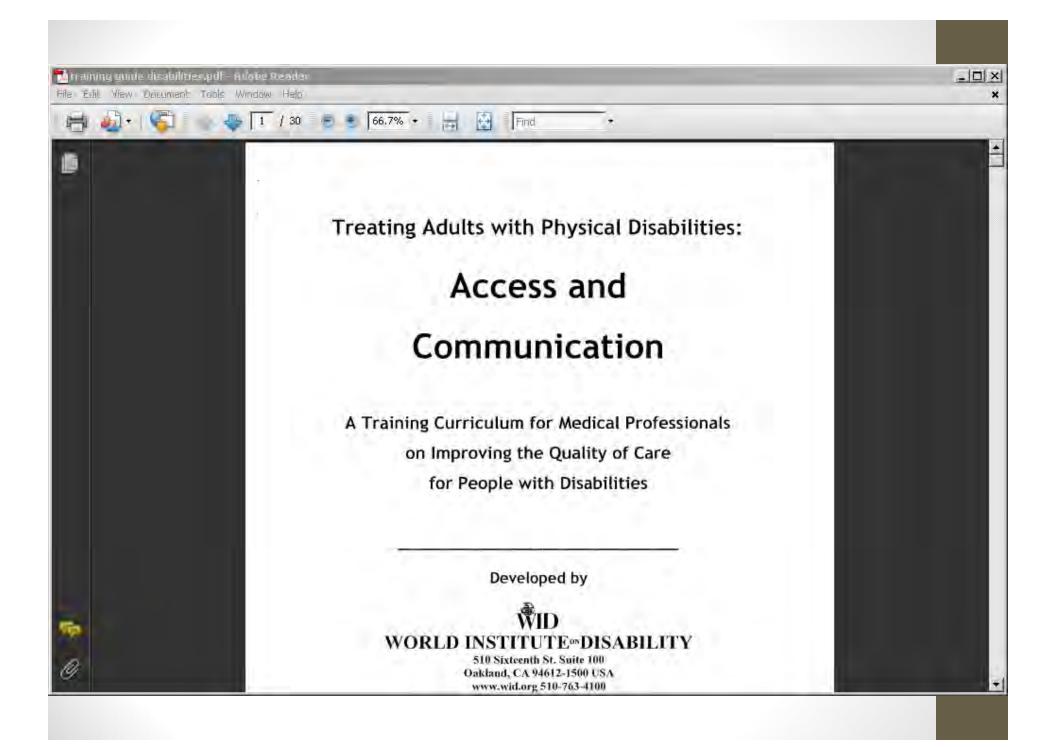


Large exam room with overhead lift

Table lowers to chair height

Potomac Street Health Center model

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 - Architecture the "built environment"
 - Attitudes cultural awareness



Potomac Street Health Center model

- In our office we strive to overcome barriers to access including those caused by:
 - Architecture the "built environment"
 - Attitudes cultural awareness
 - Communication language, lack of language, behavioral issues.



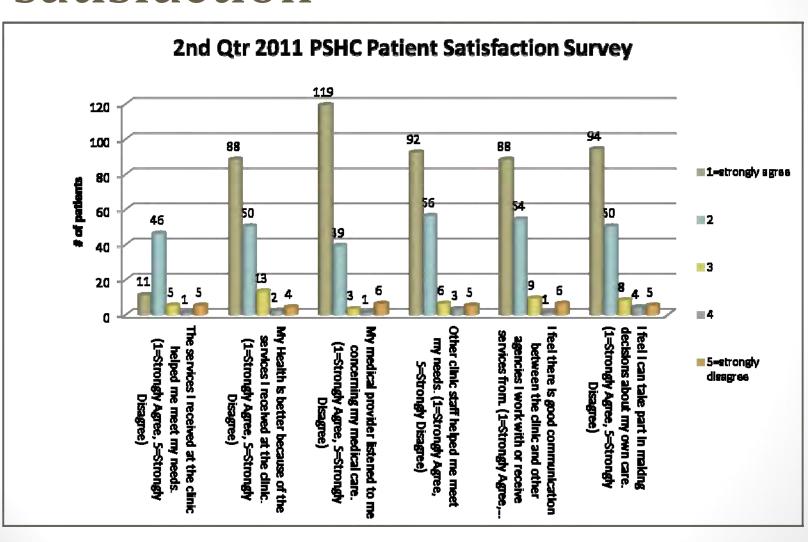
Translation line

Medical Home at MCPN Potomac Street Health Center model

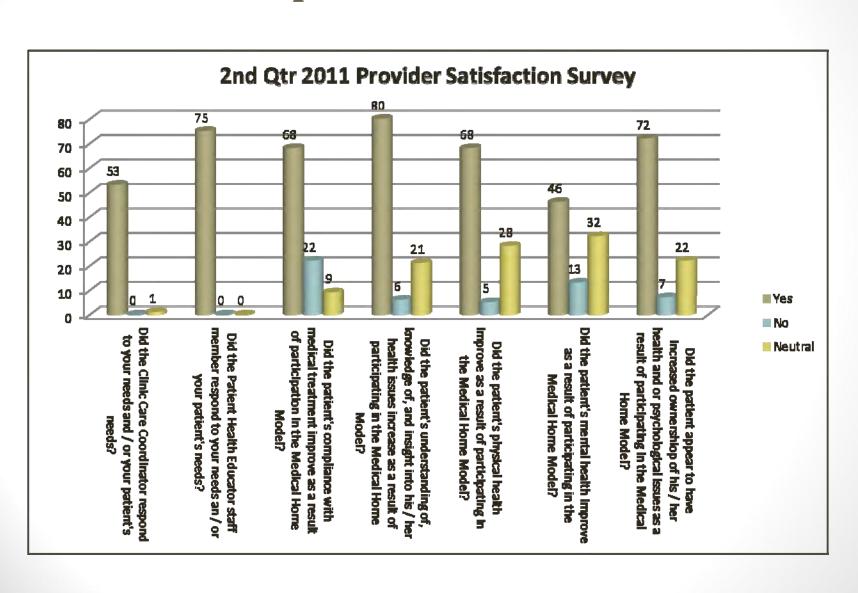
Services

- Intensive care coordination with other medical providers, home health agencies, personal care providers, etc.
- Assistance with transportation coordination
- Assistance with appropriate housing or placement
- Home visits
- Hospital visits and discharge planning
- Comprehensive Care Planning Meetings in order to bring together patient, family, care team, other specialists to develop a health care plan for the year

Outcomes: patient satisfaction



Outcomes: provider satisfaction



How do we pay for PSHC Medical Home model?

- So far with grants, but that is not sustainable
- We know that the top 3-5% of patients require care that consumes about 50% of medical care costs. Even a small percentage saved is a big amount of money.
- Can we lower ER and hospital costs, especially readmissions (that is, "downstream" costs)?
- Can MCPN get some of the "downstream" (hospital and ER) savings to spend "upstream" on coordinating care
- Accountable Care Organizations in Medicaid and Medicare hold promise as a way of paying primary care providers the upfront costs to manage care.

Stay tuned!

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