



Does Home Health Have A
Place in the Medical Home
Neighborhood?
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The Patient Centered Medical Home:
Outline of Presentation

- The state of primary care
- What is a medical home?
- Brief history of medical homes
- Evidence: impact on cost and quality
- Other state and regional medical home efforts
- The MA medical home initiative
- Where does home care fit?

2



Why Now? Primary Care Physicians

- "If you (PCPs) had to do your career over again**":
 - 28% would do again
 - 41% would be a specialist
 - 27% would not be a physician
- 2% of medical students planning on being general internists; 2.3% med-peds and 4.9% family practice**

From Stuart Pollack presentation 2009
*Physician's Foundation 10/08
**Hauer, et al, JAMA 9/10/08

3



Current Practice is Not Designed
to Maximize Outcomes



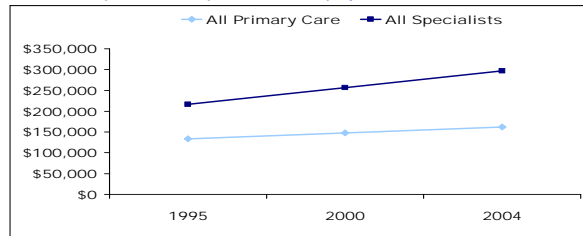
4



Primary Care Practice is in Disarray

- Low reimbursement compared to non-PCP peers (see chart)
- Long work hours; chaotic practice environment
- Low satisfaction
- Uncoordinated care transitions

Median pretax compensation of physicians, 1995–2004



Adapted from Bailit, 2008

5



“Like Hamsters on a Treadmill”

“Across the globe doctors are miserable because they feel like hamsters on a treadmill. They must run faster just to stand still...The result of the wheel going faster is not only a reduction in the quality of care but also a reduction in professional satisfaction and an increase in burnout among physicians.”

(Morrison and Smith, BMJ 2000; 321:1541)

Thanks to: Robert A. Berenson, Alliance for Health Reform presentation, 22 September 2008

6



The Medical Home is not new...

- ❑ **1967: Introduction**
 - American Academy of Pediatrics (AAP) introduced the medical home concept, initially referring to a central location for archiving a child's medical record.
- ❑ **1980-present: Refinement**
 - AAP refined the concept to relate especially to children with special needs
- ❑ **2000-present: Extension**
 - AAFP and ACP developed and extended the concept to include care for all patients and patient centeredness
- ❑ **2006-07: Metrics and Linkages**
 - AAFP, AAP, ACP and AOA (with input from NCQA) develop common metric for recognizing “patient-centered medical home” (PCMH) and link PCMH to physician payment reform

Source: Pawlson, NCQA, 2007

7



What is a medical home (In One Slide)?

Weissman's “Primary Care IMPACT”[™] of Medical Homes

- **I**ndividualized Care
- **M**ulti-payer payment reforms
- **P**opulation management
- **A**ctivated (engaged) patients and families
- **C**oordinated community-based care across settings
- **T**eam-based approach

* Reformulated from: “Joint Principles” Endorsed by Four National Primary Care Specialty Societies

8



Will medical homes improve quality and lower costs (or is this just “faith-based” policy-making)?

9



Advanced Primary Care Is Associated With Better Outcomes and Lower Utilization

- ❑ A primary care-oriented system:*
 - Reduces mortality; offers better preventive care, fewer tests, higher patient satisfaction; and, reduces health disparities
- ❑ More “medical homeness” ...
 - associated with fewer hospitalizations and ER visits for kids with chronic conditions**
- ❑ Group Health Cooperative PCMH Pilot in Seattle, 2009 Study***
 - Fewer ER visits and ACSCs
 - Better on 6 of 7 patient experience scales
 - 10% provider burnout compared with 30% for controls
 - Significant gains in composite quality measure
 - No significant differences in overall costs (although this also means that all investment costs in PCMH redesign were recouped within the first year)

Sources: *Phillips R, Starfield B. Why does a U.S. primary care physician workforce crisis matter? *American Family Physician* Aug 1, 2004; Ballit, M. PCPCC, 2008; Shih 1992, 1994; **Cooley et al. *Pediatrics*. Vol. 124 No. 1 July 2009; *** Reid et al 2009

10



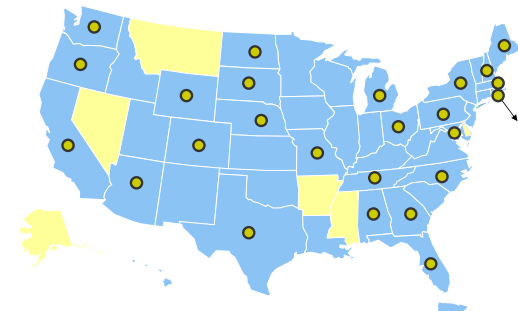
Experience in Other States

11



Patient-Centered Medical Home

2009 Overview of Pilot Activity and Planning Discussions



- Multi-Payer pilot discussions/activity
- Identified pilot activity
- No identified pilot activity – 6 States

Source: <http://www.pcpcc.net/content/generalf-presentation-materials>



Some Operational State-Wide Models

- ❑ Community Care of North Carolina
 - Manages care for rural Medicaid patients; > 3,000 physicians in 13 networks. Care managers and medical mgt staff work with local area networks to identify high-cost patients and services and develop plans to manage utilization and cost; Actuarial study by Mercer reported program savings of \$124 million in SFY04
- ❑ Vermont Blueprint
 - Integrated Pilot - Local "Community Care Teams" work with providers to coordinate patient care, support population management; DPH district office provides a public health specialist
- ❑ PA Chronic Care Commission on Reimbursement and Cost Reduction
 - Gov. Rendell Executive Order: 6-region roll-out; 75,000 patients per region; Paid for by all commercial plans, Medicaid MCOs (but not FFS), and private grant funding

Source: L. Allen Dobson, MD, presentation to ERISA Industry Committee, Washington, DC, March 12, 2007

13



The Massachusetts Medical Homes State-wide Initiative

14



Medical Home Initiative - Mission and Goal of the Secretary of EOHHS

Mission:

Design and implement a system to support high-performing, patient-centered primary care delivery across the Commonwealth of Massachusetts.

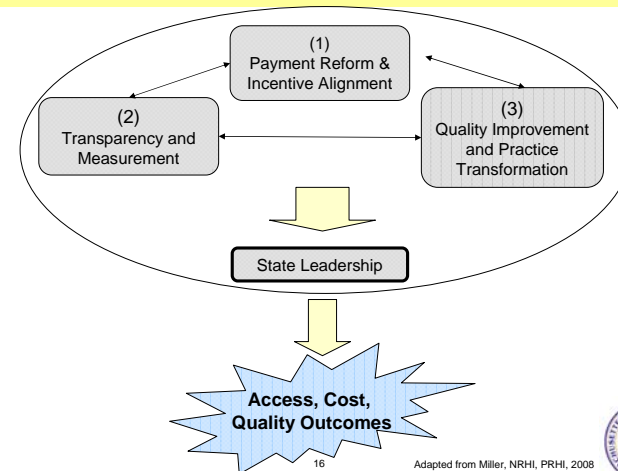
Goal:

Transform all primary care practices into high-performing, advanced medical homes by 2015

15



Vision For Success

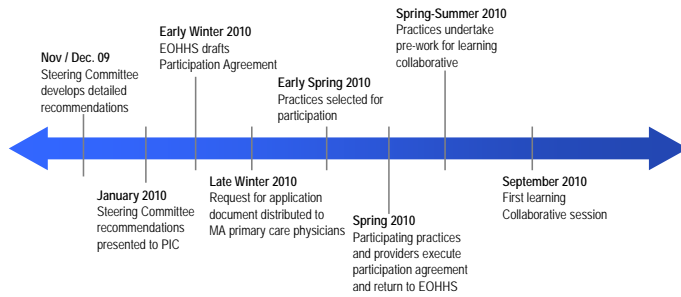


16

Adapted from Miller, NRHI, PRHI, 2008



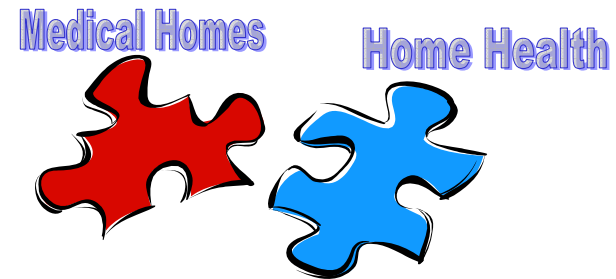
MA PCMHI Timeline



17



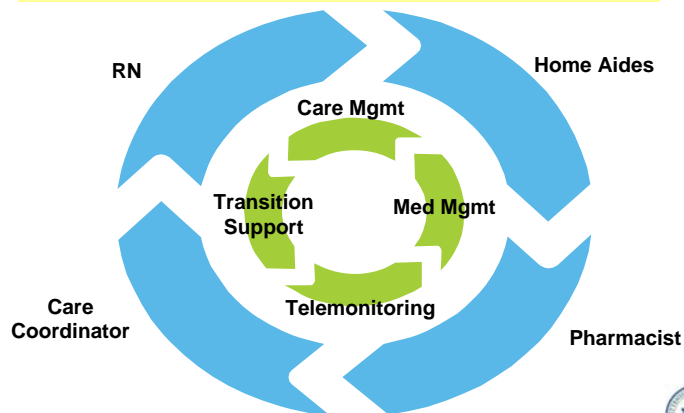
How does home health care fit in the PCMH model?



18



The Role of Home Health Care in the Medical Home Neighborhood



Thanks to dovetail, inc

19



The Relation of Home Care Networks to Medical homes

- ☐ PCMHs will need:
 - Chronic Care Management, integrated into the practice
 - Patient Self Management Programs
 - 24/7 Care
 - Enhanced community ties
- ☐ Home care networks can serve as:
 - Community-based care managers for the primary care practices
 - Fully-developed, single entry point, "No Wrong Door" approach to community services.
 - Age-integrated, adult lifespan coverage
 - Source of knowledge of current programs and care plan development.



Thanks to Al Norman, Mass Home Care; Pat Kelleher whitepaper

20



Aging Services Access Points (ASAPs) can play many roles in coordinating with medical homes

- ❑ Identify clients without a PCP or those who don't appropriately use primary care.
- ❑ Discuss the client/family the importance of regular contact with PCP
- ❑ Assist with scheduling appointments
- ❑ Authorize transportation for appointments.
- ❑ Help MD office coordinate services in the home.
- ❑ Offer medical advocates to help consumers prepare for and process PCP visits.
- ❑ Perform screenings, assessments, case management and coordination of home and community-based care



Thanks to Al Norman, Mass Home Care

21



Medicare Demonstration May Offer Additional Opportunity

- ❑ Medicare is only major payer in MA that is not involved in the PCMH
- ❑ CMS has announced the Multi-payer Advanced Primary Care Practice (MAPCP) Demonstration; RFP expected this fall
- ❑ Selection criteria for states include:
 - Be an "established state-led multi-payer" PCMH initiative
 - Demonstrate mechanism to integrate community-based resources
- ❑ MA has given input to CMS on terms of participation and criteria for states, but we are also preparing to meet current criteria

22



Summary

- ❑ An emerging evidence base on medical homes finds improved quality, patient experience, and cost control
- ❑ The large number of initiatives nation-wide provide a great learning opportunity.
- ❑ Massachusetts is poised to launch its own initiative
- ❑ Home health care can play a vital role in managing high risk patients
- ❑ Cost savings and quality improvement will only happen when the care delivery process changes, *and* when patients are engaged in prevention and self-management.

23

