Slide 1

A HOME AWAY FROM HOME

COLLEGE HEALTH AND THE PATIENT-CENTERED MEDICAL HOME

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SESSION OBJECTIVES

- Describe the development of the Medical Home model.
- Explain the key elements of a Medical Home.
- Discuss challenges and advantages of implementing Medical Home in the college health setting.

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MEDICAL HOME

The **Medical Home**, also known as the **Patient Centered Medical Home** (PCMH), is defined as "an approach to providing comprehensive primary care ... that facilitates partnerships between individual patients, and their personal providers, and when appropriate, the patient's family". The provision of medical homes may allow better access to health care, increase satisfaction with care, and improve health.

❖ Wikipedia

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American Academy of Pediatrics

- 1967
  - Standards of Child Health Care
  - Proposed system to coordinate care of children with special health needs
  - Emphasis on information with a single central repository of a child's medical records where information from all sources would be collected
- 1992
  - Policy statement defining Medical Home
  - "Accessible, continuous, comprehensive, family centered, coordinated and compassionate" pediatric care.

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Value Based Health Care Reform

Principles-Payment aligned with outcomes

- Access
- Care Coordination
  - Transfer and exchange of Information
  - Accountability
- Consumerism
- Health IT as an enabler, not a driver

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Legislation

- Patient Protection and Affordable Care Act
  - Calls for investments in patient-centered care.
  - PCMH is an important part of this care; necessary, but not sufficient.
  - Accountable Care Organizations create the neighborhood; PCMH are the home.
- ARRA
  - HITECH-"Medicare and Medicaid EHR Incentive Programs will provide incentive payments…(to) adopt, implement, upgrade or demonstrate meaningful use of certified EHR technology."

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Accountable Care Organizations

- Change in payment system for Medicare beneficiaries
- Holds organization responsible for controlling cost, improving quality, and the experience for a population of patients with performance risk-based reimbursement
- Central role of primary care with PCMH
- Requirements:
  - Information about patient
  - Population management ability
  - Resources for patient self-management
  - Culture of teamwork
  - Coordinated relationships with other providers
  - Ability to report and measure quality of care
  - Ability to manage financial risk
  - Commitment and systems to improve performance

Center for Healthcare Quality and Payment Reform

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Patient-Centered Medical Home

- Joint Principles
  - Personal physician
  - Physician directed medical practice
  - Whole person orientation
  - Care is coordinated and/or integrated across all elements of the health care system
  - Quality and safety are hallmarks of the medical home
- Additional elements
  - Enhanced access to care
  - Payment

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Operational Characteristics

- Patient-centered care
- Comprehensive care
- Coordinated care
- Superb access to care
- Systems-based approach to quality and safety

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NCQA

- 2006: Physician Practice Connections® (PPC)
  - Recognition of practices using information technology and systematic processes
- 2008: Physician Practice Connections–Patient-Centered Medical Home (PPC-PCMH™)
  - Recognition of primary care practices functioning as patient-centered medical homes
- 2011: PCMH 2011
  - Emphasis on patient-centeredness and patient experience of care
  - Reinforces incentives for meaningful use

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NCQA 2011

- 6 standards, 27 elements, 149 factors
  - Scored on 0 to 100 point scale
  - 6 must-pass elements
- Three levels of recognition based on scoring
  - Level 1 Recognition: 35 – 59 points, all 6 must-pass elements
  - Level 2 Recognition: 60 – 84 points, all 6 must-pass elements
  - Level 1 Recognition: 85 – 100 points, all 6 must-pass elements

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NCQA 2011

- PCMH 1: Enhance Access and Continuity (20 points)
  - PCMH 1, Element A: Access During Office Hours
- PCMH 2: Identify and Manage Patient Populations (16 points)
  - PCMH 2, Element D: Use Data for Population Management
- PCMH 3: Plan and Manage Care (17 points)
  - PCMH 3, Element C: Care Management
- PCMH 4: Provide Self-Care and Community Support (9 points)
  - PCMH 4, Element A: Support Self-Care Process
- PCMH 5: Track and Coordinate Care (18 points)
  - PCMH 5, Element B: Track Referrals and Follow-Up
- PCMH 6: Measure and Improve (20 points)
  - PCMH 6, Element C: Implement Continuous Quality Improvement

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- First accrediting body to conduct on-site survey for organizations seeking PCMH validation
- 2009: Accredited organizations allowed to choose Medical Home chapter as part of survey
- 2011: Pilot Medical Home certification (separate from accreditation)
- 5 Core Standard Areas
- Electronic Data Management as a tool to achieve the standards.

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AAAHC

- Foundation is relationship between patient and Medical Home
- Medical Home assessed from perspective of patient
- 5 Core Standard Areas
  - Relationship
  - Continuity of Care
  - Comprehensiveness of Care
  - Accessibility
  - Quality
- Electronic Data Management as a tool to achieve the standards.

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The Joint Commission Accreditation Ambulatory Care

- 2011: Primary Care Home Option
  - Available only to accredited ambulatory care organizations
  - No special application requirements
- Current ambulatory care accreditation
  - ~900 Elements of Performance
  - Primary Care Home option
    - 123 existing EPs
    - Plus 54 new EPs

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JOINT PRINCIPLES	NCQA	AAAHC	The Joint Commission
Personal physician	Practice team	Physician or physician-directed health care team	
Physician directed medical practice	Plan and Manage Care	Physician-directed health care team	
Whole person orientation	Provide Self-Care and Community Support	Relationship between patient and Medical Home	Patient-centered care
Care is coordinated and/or integrated	Track and Coordinate Care	Continuity of Care Comprehensiveness of Care	Continuity of Care Comprehensive Care
Quality and safety	Measure and Improve Performance	Quality	Systems-based approach to quality and safety
Enhanced access to care	Enhance Access and Continuity	Accessibility	Access to care
	Identify and Manage Patient Populations		

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Young Adult Population

- CDC: 96% of 18-24-year-olds report being in excellent, very good, or good health; only 4.6% report any limitations.
- Lowest insurance rate
  - ACHA 10%.
- High emergency department use.
- Disease burden: mental health, preventable accidents and injuries.

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"Bridges to Health" model:

Various subpopulations with distinct needs

Overall Adult Population	Student Population
Healthy Individuals	Healthy Individuals
Pregnant mothers and infants	Pregnant mothers and infants
Acutely ill individuals	Acutely ill individuals
Individuals with serious disabilities who are stable	Individuals with serious disabilities who are stable
Individuals with chronic conditions who have normal functioning	Individuals with chronic conditions who have normal functioning
Individuals with chronic conditions who have limited reserve and experience exacerbations	Individuals with chronic conditions who have limited reserve and experience exacerbations
Frail individuals	Frail individuals

Milbank Quarterly, Vol. 85, No. 2, 2007 (pp. 185-208)

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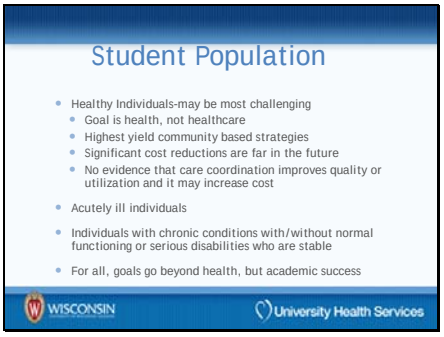

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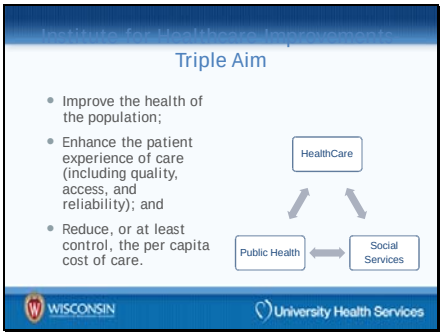

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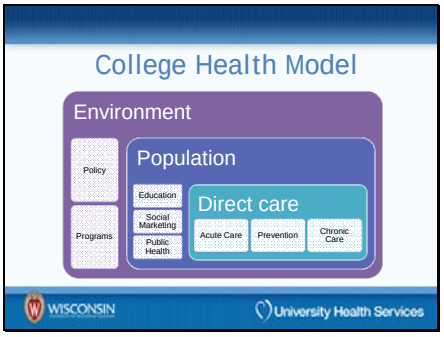

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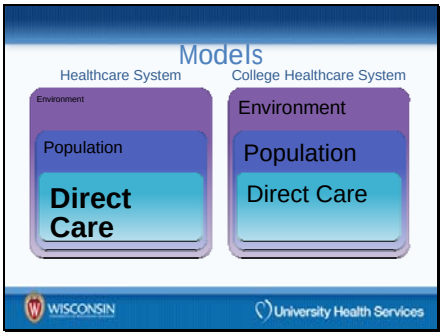

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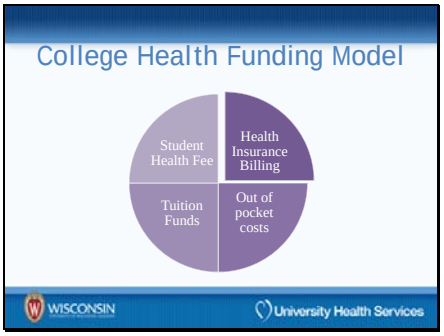

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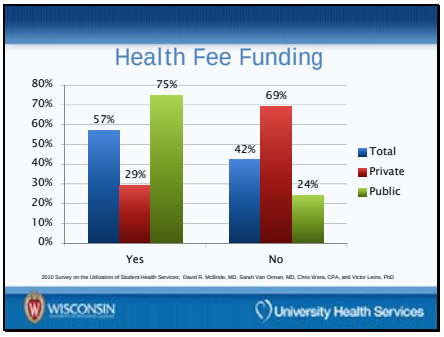

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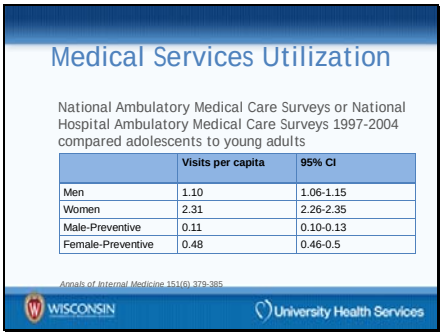

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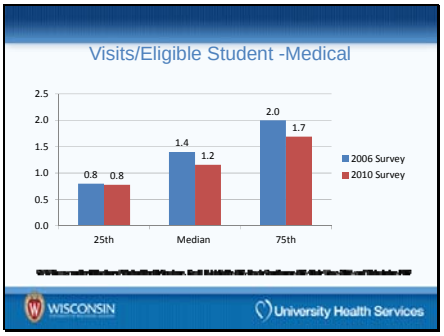

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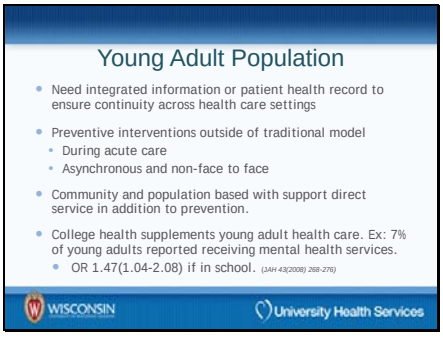

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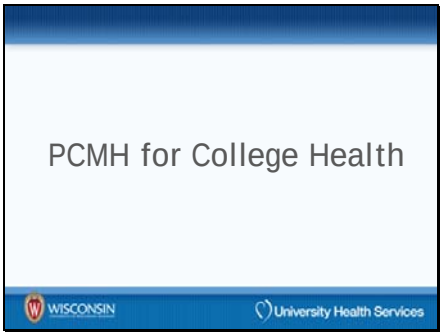

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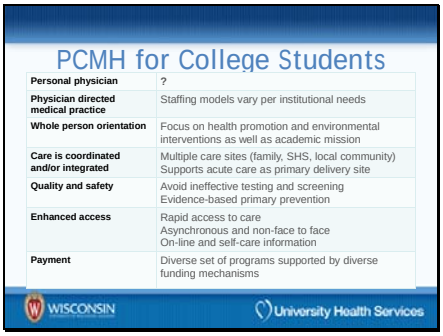

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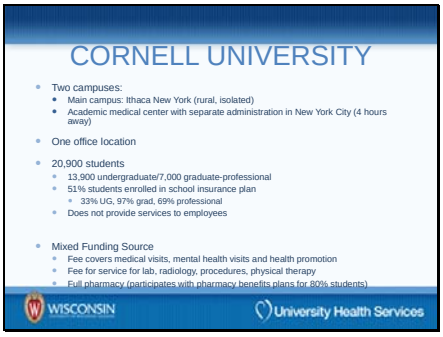

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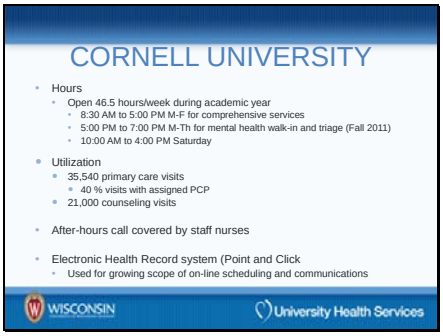

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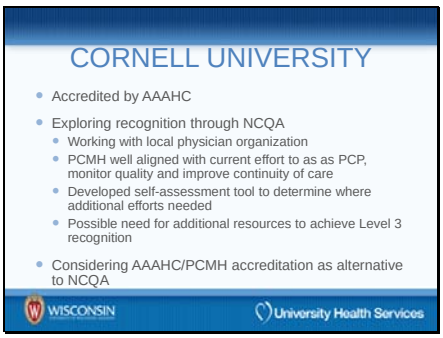

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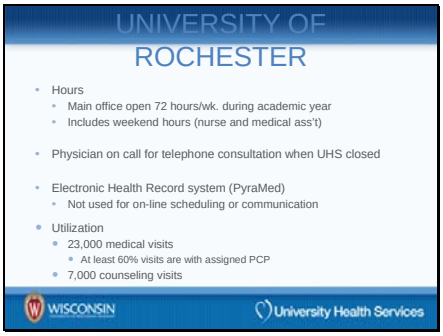

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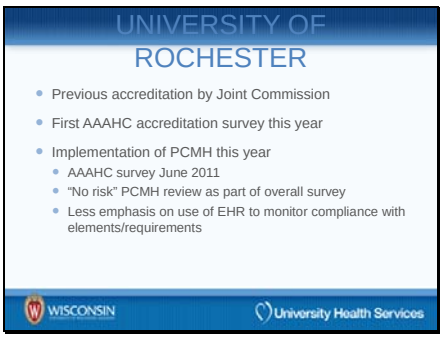

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UNIVERSITY OF ROCHESTER

- Incremental implementation - invite specific patients to join PCMH program
  - Start with non-student patients
  - Expand to include some students (graduate students with chronic illness)
- Patient has to select PCMH - may not have another "home"
  - Unclear how to manage students who go home for summer, retirees who go south for winter

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UNIVERSITY OF GEORGIA

- New Academic Medical Center started 2010
- One location
- 34,885 students
  - 26,000 undergraduate/8,700 graduate-professional
  - ? students enrolled in school insurance plan
  - Only ancillary services available to employees
- Dedicated health service fee for students
  - $191 per semester in 2010-2011
  - Covers primary care, counseling, health promotion

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UNIVERSITY OF GEORGIA

- Hours
  - Open 76 hours/week during academic year
    - 8:00 AM – 8:00 PM Monday – Friday
    - 10: AM – 5:00 PM Saturday and Sunday
- After-hours coverage referred to ER
- Utilization
  - 59,000 direct primary care and women's health visits
    - 49% with assigned PCP, 83% with PCP team
  - 13,000 counseling visits
- Electronic Health Record system (Point and Click)
  - Open Communicator for adding health information to record, immunization record review, scheduling
  - 50 % appointments scheduled on-line

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UNIVERSITY OF GEORGIA

- Implemented principles of advance access and medical home Fall 2008
  - All students assigned to PCP and team
    - 49 % students seen by PCP, 83 % seen by team
    - Others seen in Urgent Care, or specialty clinics Sports Medicine, Women's Clinic
  - "Clinical excellence teams" for selected conditions
- Accredited by Joint Commission
- Considering optional accreditation as PCMH by Joint Commission

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UNIVERSITY OF GEORGIA

- Current areas of focus
  - PC.10.10.10 The patient has access to the organization 24 hours a day, seven days a week.
    - *Note: Access may be provided through a number of methods, including telephone, email, flexible hours, websites, and portals.
  - Clinician Advice-contracting with GM Southwest to offer 24/7 advice line
  - Prescription refills, lab results, registration and billing information
  - Establishing health literacy tools
  - Electronic prescribing
  - Establishment of operational and clinical benchmarks with other student health centers

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PCMH in the College Health setting CHALLENGES

- Preference for access over continuity
- Instability
  - Insurance
  - Geographic Location
- Articulation with other medical systems and/or providers
- Evolving payment structures
- Ownership and control
- Resolving disputes about care
- Is this what healthy people need?

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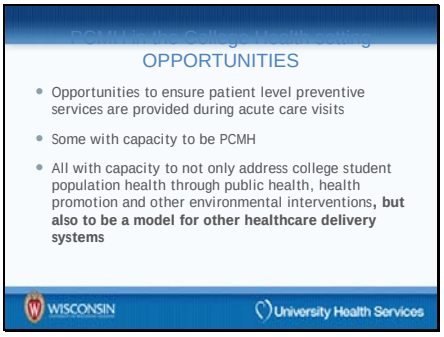

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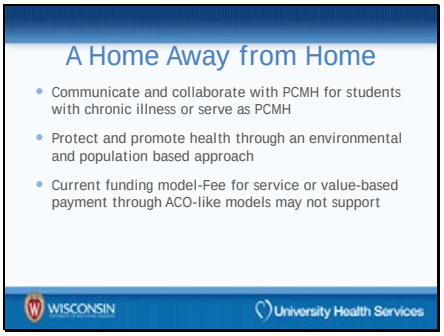

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