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A HOME AWAY FROM HOME


COLLEGE HEALTH AND THE PATIENT-CENTERED MEDICAL HOME
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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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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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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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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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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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- 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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Joint Principles of the 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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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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Primary Care Home 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 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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JOINT PRINCIPLES	NCOA	AACN	AAHC
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	Continuity of 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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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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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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- 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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"Bridges to Health" model: Various subpopulations with distinct needs

Overall Adult Population	Student Population
<ul style="list-style-type: none"> • Healthy Individuals • Pregnant mothers and infants • Acutely ill individuals • Individuals with serious disabilities who are stable • Individuals with chronic conditions who have normal functioning • Individuals with chronic conditions who have limited reserve and experience exacerbations • Frail individuals 	<ul style="list-style-type: none"> • Healthy Individuals • Pregnant mothers and infants • Acutely ill individuals • Individuals with serious disabilities who are stable • Individuals with chronic conditions who have normal functioning • Individuals with chronic conditions who have limited reserve and experience exacerbations • Frail Individuals

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

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Student Population

- Healthy Individuals-may be most challenging
 - Goal is health, not healthcare
 - Highest yield community based strategies
 - Significant cost reductions are far in the future
 - No evidence that care coordination improves quality or utilization and it may increase cost
- Acutely ill individuals
- Individuals with chronic conditions with/without normal functioning or serious disabilities who are stable
- For all, goals go beyond health, but academic success

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College Health Model

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Triple Aim

- Improve the health of the population;
- Enhance the patient experience of care (including quality, access, and reliability); and
- Reduce, or at least control, the per capita cost of care.

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Models

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Healthy Campus 2010/2020

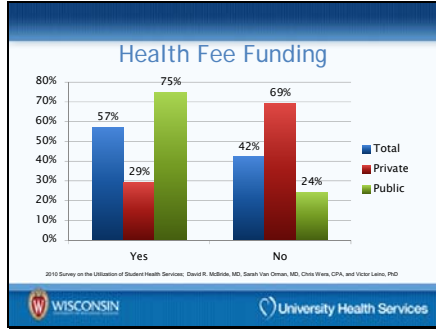
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College Health Funding Model

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- ### Young Adult Population
- Need integrated information or patient health record to ensure continuity across health care settings
 - Preventive interventions outside of traditional model
 - During acute care
 - Asynchronous and non-face to face
 - Community and population based with support direct service in addition to prevention.
 - College health supplements young adult health care. Ex: 7% of young adults reported receiving mental health services.
 - OR 1.47(1.04-2.08) if in school. (LAH 43(2008) 268-276)

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Medical Services Utilization

National Ambulatory Medical Care Surveys or National Hospital Ambulatory Medical Care Surveys 1997-2004 compared adolescents to young adults

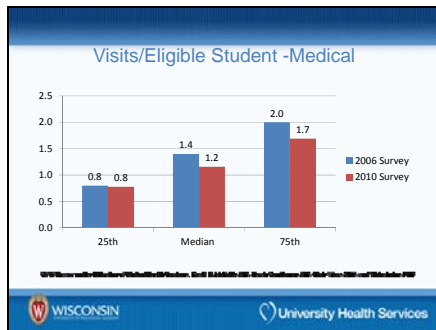
	Visits per capita	95% CI
Men	1.10	1.06-1.15
Women	2.31	2.26-2.35
Male-Preventive	0.11	0.10-0.13
Female-Preventive	0.48	0.46-0.5

Annals of Internal Medicine 151(6): 379-385

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PCMH for College Health

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PCMH for College Students

Personal physician	?
Physician directed medical practice	Staffing models vary per institutional needs
Whole person orientation	Focus on health promotion and environmental interventions as well as academic mission
Care is coordinated and/or integrated	Multiple care sites (family, SHS, local community) Supports acute care as primary delivery site
Quality and safety	Avoid ineffective testing and screening Evidence-based primary prevention
Enhanced access	Rapid access to care Asynchronous and non-face to face On-line and self-care information
Payment	Diverse set of programs supported by diverse funding mechanisms

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CORNELL UNIVERSITY

- Two campuses:
 - Main campus: Ithaca New York (rural, isolated)
 - Academic medical center with separate administration in New York City (4 hours away)
- One office location
- 20,900 students
 - 13,900 undergraduate/7,000 graduate-professional
 - 51% students enrolled in school insurance plan
 - 33% UG, 97% grad, 69% professional
 - Does not provide services to employees
- Mixed Funding Source
 - Fee covers medical visits, mental health visits and health promotion
 - Fee for service for lab, radiology, procedures, physical therapy
 - Full pharmacy (participates with pharmacy benefits plans for 80% students)

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UNIVERSITY OF ROCHESTER

- Academic Medical Center
- Three office locations
- 8,000 students
 - 5,000 undergraduate/3,000 graduate-professional
 - 3,500 students enrolled in school insurance plan
 - Also serves 3,000 employees (primary care)
- Dedicated health service fee for students
 - \$524 in 2010-2011
 - Covers primary care, counseling, health promotion

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CORNELL UNIVERSITY

- Hours
 - Open 46.5 hours/week during academic year
 - 8:30 AM to 5:00 PM M-F for comprehensive services
 - 5:00 PM to 7:00 PM M-Th for mental health walk-in and triage (Fall 2011)
 - 10:00 AM to 4:00 PM Saturday
- Utilization
 - 35,540 primary care visits
 - 40% visits with assigned PCP
 - 21,000 counseling visits
- After-hours call covered by staff nurses
- Electronic Health Record system (Point and Click)
 - Used for growing scope of on-line scheduling and communications

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UNIVERSITY OF ROCHESTER

- Hours
 - Main office open 72 hours/wk. during academic year
 - Includes weekend hours (nurse and medical ass't)
- Physician on call for telephone consultation when UHS closed
- Electronic Health Record system (PyraMed)
 - Not used for on-line scheduling or communication
- Utilization
 - 23,000 medical visits
 - At least 60% visits are with assigned PCP
 - 7,000 counseling visits

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CORNELL UNIVERSITY

- Accredited by AAAHC
- Exploring recognition through NCQA
 - Working with local physician organization
 - PCMH well aligned with current effort to as as PCP, monitor quality and improve continuity of care
 - Developed self-assessment tool to determine where additional efforts needed
 - Possible need for additional resources to achieve Level 3 recognition
- Considering AAAHC/PCMH accreditation as alternative to NCQA

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UNIVERSITY OF ROCHESTER



- Previous accreditation by Joint Commission
- First AAAHC accreditation survey this year
- Implementation of PCMH this year
 - AAAHC survey June 2011
 - "No risk" PCMH review as part of overall survey
 - Less emphasis on use of EHR to monitor compliance with elements/requirements

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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

- 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



- 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



- 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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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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**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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PCM Models: College Health Setting

OPPORTUNITIES

- Opportunities to ensure patient level preventive services are provided during acute care visits
- Some with capacity to be PCMH
- All with capacity to not only address college student population health through public health, health promotion and other environmental interventions, but also to be a model for other healthcare delivery systems

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Quality Outcomes

- Financial outcomes impractical except in mental health
- Patient level outcomes-experience of care and quality measures
- Population/Environment Based

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A Home Away from Home

- Communicate and collaborate with PCMH for students with chronic illness or serve as PCMH
- Protect and promote health through an environmental and population based approach
- Current funding model-Fee for service or value-based payment through ACO-like models may not support

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