

THE REINVENTED MEDICAL HOME

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“We don’t have a healthcare delivery system in this country. We have an expensive plethora of uncoordinated, unlinked, economically segregated, operationally limited micro systems, each performing in ways that too often create sub-optimal performance, both for the overall health care infrastructure and for individual patients.”

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George Halverson, from “*Healthcare Reform Now*” 2

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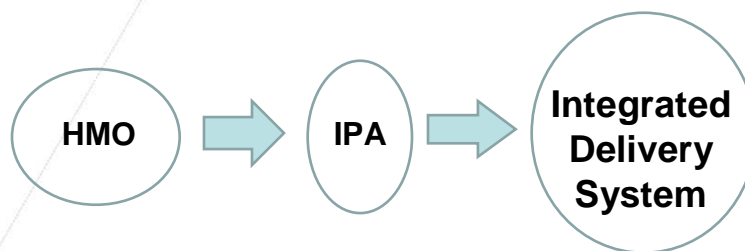
Health Care Delivery System Soon to be the way it was.....

- Patients and families navigate unassisted among different providers and care settings
- Poor communication and lack of accountability among multiple providers
- Absence of peer accountability, quality, infrastructure, clinical information system

3



Toward A More Coordinated Systemthe way it will be



4



The Dilemma



- Transforming primary care practices into Medical Home and obtaining sustainable payment for services

BUT

- Employers and payers tie reimbursement to demonstrated value and potential to save money

5



Toward A More Coordinated System

Legislation

Patient Protection and Affordable Care Act –
March 2010

Accountable Care Organizations (ACO)
Vehicle for increasing value in the healthcare system
through improved quality of care and reduced cost.

6



Patient Centered Medical Home

The Definition:



- Direct relationship between patient and their primary care physician
- Physician coordinates patient care with a team of healthcare professionals
- Physician is accountable for health care and arranges for appropriate care with other qualified providers and resources as needed.

7



Medical Home Reinvention How, When, Who...

1967: American Academy of Pediatrics (AAP)

- Single source of a child's pediatric records
- Centralized medical records

2002: AAP Description

- Accessible
- Continuous
- Comprehensive
- Patient/Family Centered
- Coordinated
- Compassionate
- Culturally Effective

8



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Medical Home Reinvention (Cont'd)

Joint Principles (AAP, ACFP, ACP, AOP)

- Personal physician
- Physician directed medical practice
- Whole person orientation
- Coordinated care
- Quality and safety
- Enhanced access
- Payment reform

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9



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How Does It Work?

Critical factors of a successful PCMH

- Practice organization
- Quality measures
- Health information technology
- Patient satisfaction
- Accessibility to primary care

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10



Quality Measures

- Meeting quality standards ensures positive outcomes
- Medical practice recognition
- Financial incentives for medical practices



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The PCMH Driver

National Committee for Quality Assurance (NCQA)

- Developed voluntary standards for physician practices – Physician Practice Connection
- Offers three levels of PCMH recognition tied to financial reward
- Recognized 3,100 + physicians in 600 practices; more than half of NCQA recognized practices have achieved Level 3 status.
- Revised standards available 2011

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Health Information Technology



Key Technologies

- Electronic medical record
- Electronic disease registries
- Internet communication with patients
- Electronic prescribing

13



Expanded Access to Primary Care



Primary care physician links care with other health professionals, facilities and resources

- 24 hour access
- Expanded office hours
- Same day appointments

14



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Benefits and Outcomes of PCMH

Patient: Better, safer, less costly..



Primary Care Provider: Patient focused, higher reimbursement...

Specialists: Better communication...

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15



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Benefits and Outcomes of PCMH

Hospital: Reduce admissions and focus on procedures...

Employer: Lower healthcare costs, healthier workforce...

Payer: Employer satisfaction, lower costs...

Government: Lower healthcare costs, healthier population

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16



How Does the Collaborative Work?

Providers

333,000 PCPs
ACP AAFP
AAP ABIM
AAO

Employers

Most of the Fortune 500
IBM General Motors
FedEx General Electric
Pfizer Merck
Wal-Mart Business Coalitions

80 Million Lives

**The
Patient Centered
Medical Home**

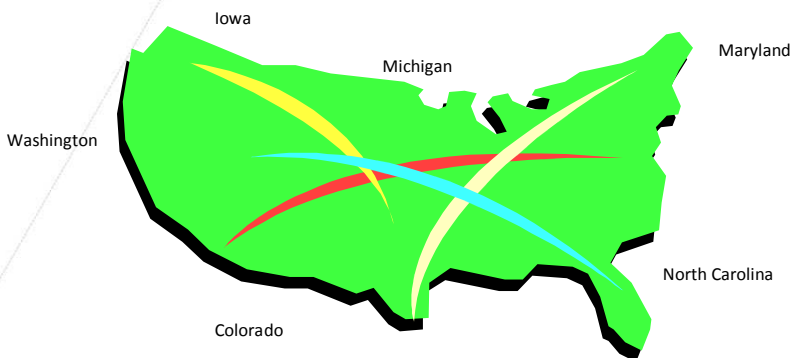
Payers

BCBSA AETNA
United Humana
CIGNA WellPoint
Kaiser

Patients



PCMH Pilots Who is driving the next steps?





Summary: Health Care Delivery

Today's Care

My patients ...

I deliver high quality care because....

Care determined by today's problem

Care varies memory of skill of the physician



PCMH

Our patients

We measure quality...

Care is determined by a **plan ...**

Care is standardized

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