

TRANSLATING EVIDENCE INTO PRACTICE: THE MEDICAL HOME AND QUALITY MEASURES

AGS

May 2010

CM+

care
management
plus

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Care Management Plus: Dissemination of Information Technology Tools for the Care of Seniors, www.caremanagementplus.org

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Medical Home Workshop Objectives

1. List key features of the Advanced Medical Home and potential barriers to implementation.
2. Understand how ACOVE Prime implements geriatric quality indicators.
3. Discuss primary care redesign and the care manager role in meeting patient/caregiver needs and in providing a population view of the clinic.

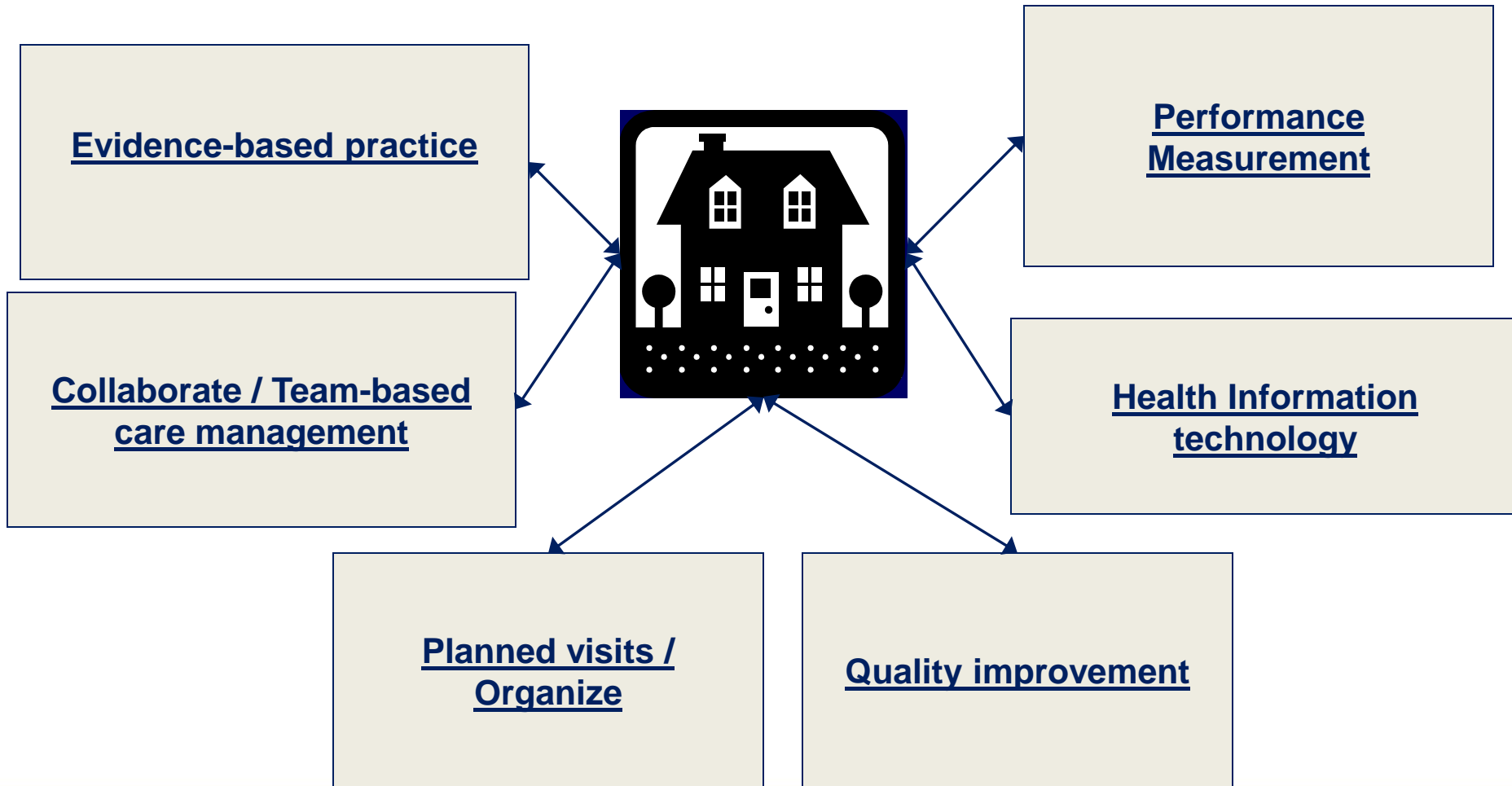
Questions: How do I adopt a medical home model?
And How do I help other primary care medical homes take better care of older adults?

Redesign again?



- The Medical Home (1977)
- Practice Redesign (1993)
- Chronic Care Model (1998)
- Idealized Design of Clinical Office Practices (1998)
- IOM Quality Chasm, Six Aims: Safe, Effective, Patient-centered, timely, efficient, equitable health care
- Future of Family Medicine's "New Model of Care" (2004)
- TransforMED (2005)
- AAFP Practice Enhancement Forum (2005)
- Joint Principles of the Patient Centered Medical Home (2007)
- The Medical Neighborhood (2008)

Elements of Medical Home



Key Attributes: Advanced Medical Home

- Organize the delivery of care for all patients according to the Care Model
- Use of evidence-based medicine and clinical decision support tools
- Coordinate care in partnership with patients and families
- Provide enhanced and convenient access to care
- Identify and measure key quality indicators
- Use health information technology to promote quality, safety, security of information, and health information exchange
- Participate in programs that provide feedback on performance & accept accountability for process improvement and outcomes

Barr, MS www.acponline.org

How can you move towards a Medical Home?

- Barriers
 - Credentialing (e.g., NCQA)
 - Availability of demonstrations / payment models
 - Variations in models
 - Investment and local gaps – care management, population metrics that matter, HIT
- System gaps
 - Geriatric specific metrics / assessments

Who would pay you for a medical home?

- Health Systems (especially self-insured)
- Payers (may require credentialing)
- Multi-payer and Medicaid State-based programs (e.g., Michigan)
 - If state-based, eventually Medicare

Resources:

http://www.medicalhomesummit.com/MHN_resources.pdf

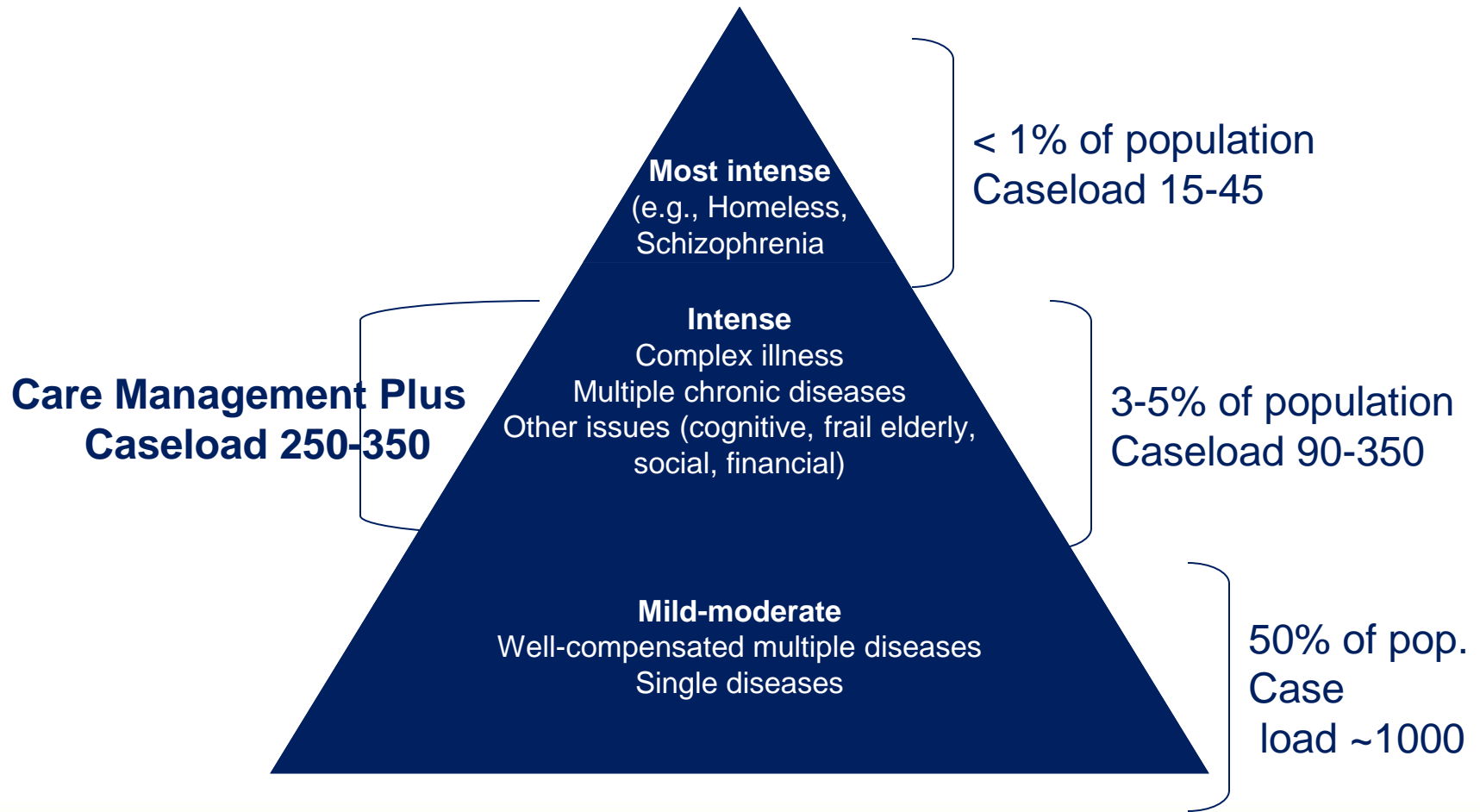
Proactive and Flexible: Care Management Plus fills in core gaps



Larger infrastructure: Electronic Health Record, quality focus

In 16 primary care clinics at Intermountain Healthcare

Care management varies in intensity and function for different populations and needs



Does CMP make a difference?

Study design

- Retrospective cohort
- Comparison of care managed (CM) patients (7 clinics) with patients from similar clinics w/out care managers (n=4)
- CM patients matched to controls on key characteristics

Outcomes

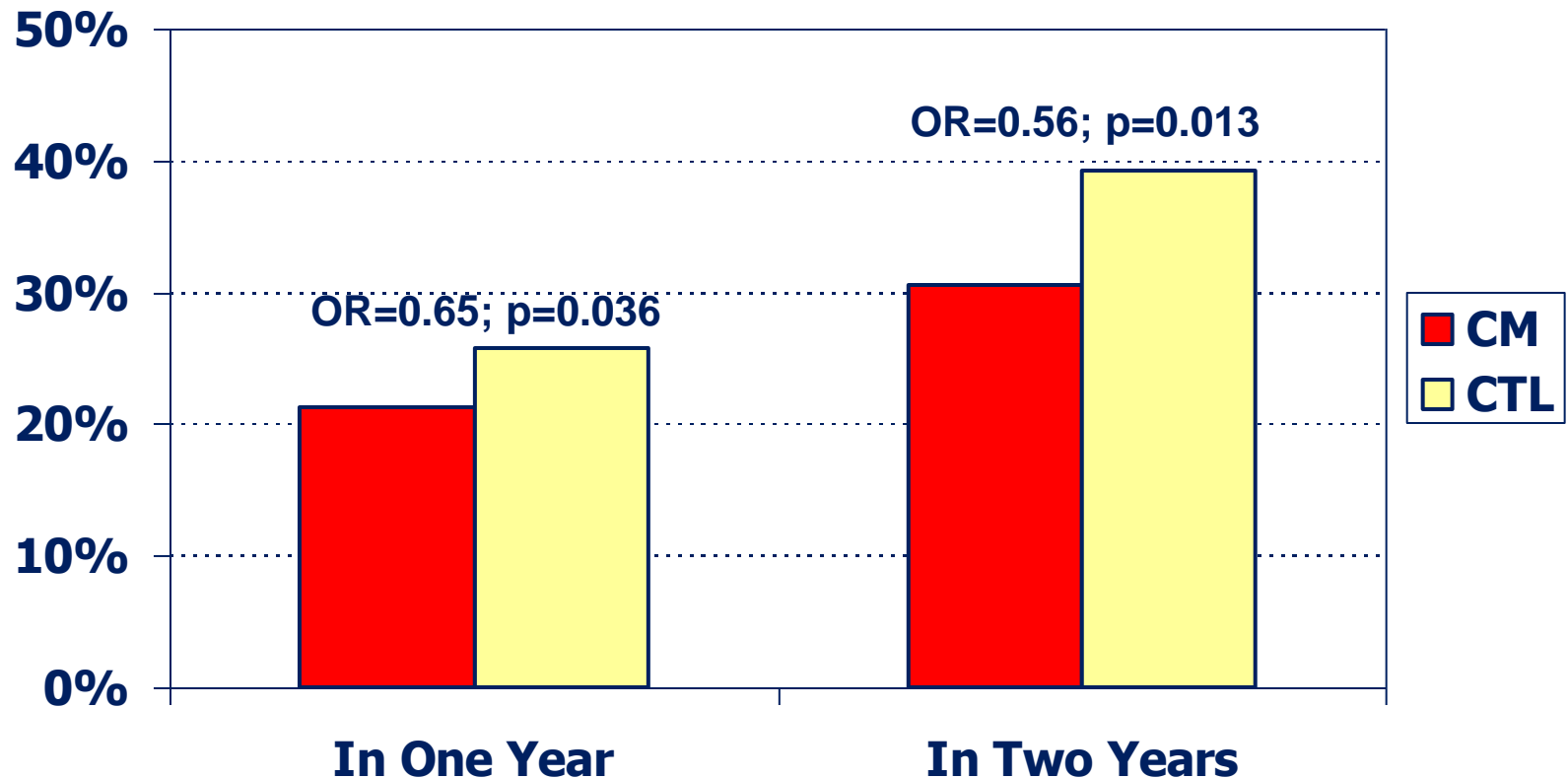
- Disease control, death, hospitalization
- Efficiency

Guideline Adherence in Diabetes: Results

Outcome	Odds Ratio
Overdue for HbA1c test	0.79*
HbA1c Tested	1.42*
HbA1c in control (<7.0)	1.24*

**p<0.01*

Reduction in hospitalizations from CM+



How does it work?

In CM+, Odds of dying were reduced by 20-40%.

Variable	Time	CM+	Control	Difference
All Patients		(N=1,144)	(N=2,288)	
	at 1 year	6.5%	9.2%	-2.7%
Deaths	at 2 years	13.1%	16.6%	-3.5%
Multiple illnesses		(N=557)	(N=1114)	
	at 1 year	6.2%	10.6%	-4.4%
Deaths	at 2 years	12.9%	18.2%	-5.3%

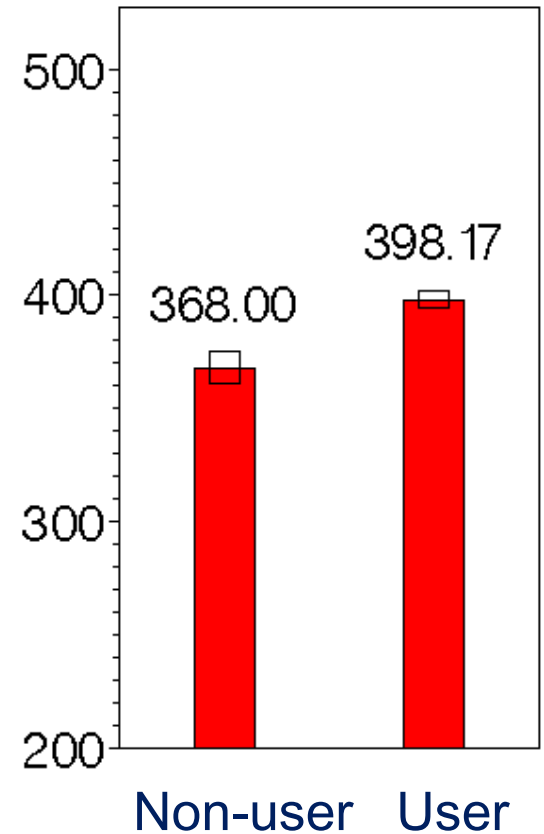
Physicians were more efficient through better documentation, a slight increase in visits, and a change in practice pattern.

- Physicians who referred to care managers:

8% more productive

than peers in same clinic

WRVU Mean



+8%

Dorr, AJMC, 2007

Physician Perspectives of Care Management

- improved productivity
- improved quality of care
- better understanding of patient status
- higher provider satisfaction

Gaps in Medical Homes

- Metrics *chosen by clinics* focus primarily on individual chronic illnesses, not functional status or geriatric syndromes
- Most current accountability models for medical homes (e.g., shared risk) *will fail* without focused interventions for at-risk patients
- HIT tracking and population management is *crucial* to success

References

- http://www.ajmc.com/supplement/managed-care/2009/A264_09dec_HlthPolicyCvrOne/A264_09dec_FriedbergS291to299
- Search terms:
 - Multi-payer Medical Home Demonstration, CMS Medical Home demonstration, Medicaid medical home demonstration