

● ● ● | Medical Home



family  
HEALTH SERVICES  
minnesota  
Family Medicine in your Neighborhood  
[www.fhsm.com](http://www.fhsm.com)




● ● ● | Our Mission

The mission of Family HealthServices Minnesota, P.A. is to provide comprehensive, patient-centered medical services, in family medicine clinics located in your neighborhood. As an independent organization of physicians, we are uniquely prepared to provide the highest quality of care and value for our patients and staff.



● ● ● | Our Vision

Family HealthServices Minnesota, P.A. will be a leader in improving the health of our community through the delivery and coordination of family and patient-centered healthcare services. We will be the clinics of choice for patients, employees, providers and the communities we serve.





● ● ● | Strategy Statement

FHSM will achieve and sustain competitive advantage by building relationships that provides the highest value, community based family medical care as measured by quality, satisfaction and efficiency.





## FHSM Medical Home - Recipe

- There are many ingredients to include in the medical home recipe.
- What are the ingredients FHSM will use in our medical home recipe?
- What do we have
- What do we need

## Building the Structure FHSM Medical Home

- Patient Centered
- Quality Driven
- Community Based
- Relationships
- Efficiency
- Physician Owned


## Strategy Input

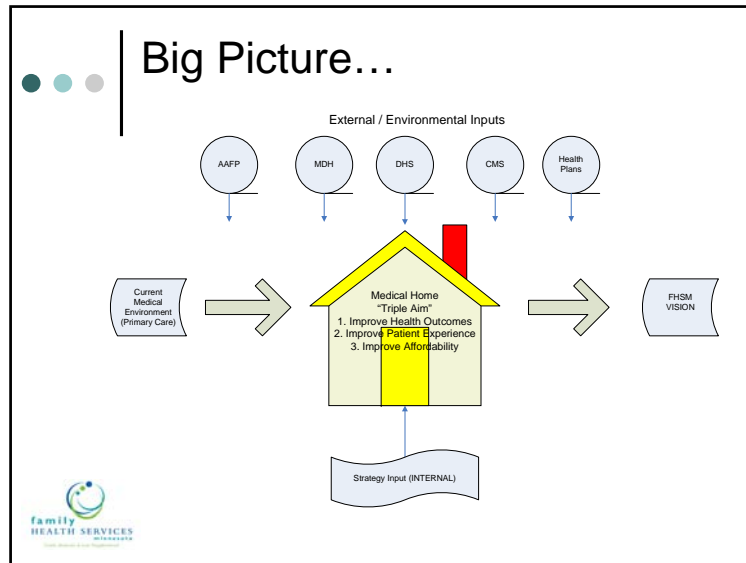
1. Patient Centered  
Access, Coordinated Care, After Hours Care, Satisfaction, Scope
2. Quality Driven  
Best Practice, Medical Home, Value & Transparency
3. Community Based  
Marketplace, Neighborhood, Outreach
4. Relationship Development  
Communication, Internal / External Relationships
5. Efficiency  
Technology, Size/Growth, Workflow of Organization / Systems, Costs/Waste
6. Physician Owned  
Voice, Lifestyle, Recruitment, Compensation



## Building the Structure FHSM Medical Home Input

- Medical Home
  - Establish FHSM Medical Home definition
    - objectives / goals
    - implementation plan
    - evaluation
  - Educate organization: staff and patients
  - Establish partnerships for improved coordination of care (specialists, hospital, long term care etc.)
  - Expand on care management roles / care coordination
  - Provide technology support for care coordination
  - Educate - Patient Centered Concepts
  - Establish community relationships, partnerships, resources
- Patient Centered
  - Access
  - Coordinated Care
  - After Hours Care / Hours of Operation
  - Satisfaction
  - Scope





- ### Common Goals of Medical Home
1. Patient Experience Outcomes
  2. Health Outcomes
  3. System Outcomes
  4. Financial Outcomes

- ### Overarching goal theme in MN to meet “The Triple Aim”
- o Triple Aim:
    - Health
      - Patient & health outcomes (such as publicly reported measures by MNMCM)
    - Experience
      - Patient engagement & activation
      - Patient access
      - Patient-centered or relationship-centric practice; personalized care
    - Affordability
      - Reduced use of resources; ER, Hospital, Unnecessary care
  - o System Outcomes:
    - Physician and staff satisfaction
    - Reliable delivery of best practices in healthcare

- ### Common Themes - Operating Principles
- o “Joint principles of Patient Centered Medical Home” (AAFP, AAP, ACP, AOA)
    - Common backbone upon which national papers / demonstration projects hang their components and criteria
    - National “State of the art” principles
      - Personal physician
      - Physician directed medical practice
      - Whole person orientation
      - Care Coordinated / integrated
      - Quality and Safety
      - Enhanced access to care
      - Payment appropriately recognizes added value

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Medical Home  
Common Themes Components &  
Performance Criteria

- Practice-based care management
- Practice-based team care
- Patient access and communication processes
- Patient tracking and registry functions
- Patient self management support
- Electronic health information technology
- Performance reporting



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Medical Home Components / Criteria  
Significant Differences

- Paradigm for care management
- Behavioral health professional routinely on care team
- Leadership / Change Management / Culture Change
- Medical Home Criteria Sets or Tools



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MN Medical Home  
Components & Performance Criteria  
Commonalities


- Care Management / Care Managers / Proactive system for following rosters of patients
- Team care structure and leadership
- EMR
- Registry / Preventive and Chronic Care Reports
- Evidence based guidelines embedded
- Systems for patient self-management, decision making, patient activation or involvement in practice
- Pre-visit, between visit care / planned exams / standardized workflow, QI as a normal part of clinic life
- Systems for performance measurement, tracking, feedback and reporting



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Medical Home Outcomes – Emerging  
in Minnesota



- DIAMOND Initiative – (A medical home for depression in primary care)
  - Early data shows a 50% response rate to the program and a 35.5% remission rate, which is quite promising
- DIAMOND involves many principles or components of health care home
  - PCP working with care managers
  - Care managers supervised by consulting psychiatrist using registry
  - Evidence based protocols
  - Performance reporting
  - Modified care management fee payment system on top of fee for service
  - Broad coalition of provider groups, health plans, and quality organizations involved with the effort.







### Medical Home Questions & Issues for Discussion

- o Medical Home as a philosophy vs. location-based or provider based concept
- o Medical Home anchored in disease populations vs. system populations
- o Medical Home – a way out of a familiar provider-payer stalemate
- o What health care home is not...a gatekeeper model in disguise





### Medical Home Philosophy vs. Location Based or Provider Based

- o Medical home can be viewed as a philosophy or location based / provider based concept.
- o Who achieves the medical home?
  - Individual physicians
  - Individual Clinics
  - FHSM Organization




### Medical Home - Disease Population vs. System Population


- o Medical home concepts got their start in pediatric populations – children with special needs. DIAMOND has been compared to “medical home for depression” and many systems strive for medical home-type function for chronic illness such as diabetes.
- o Is the medical home concept & criteria to emphasize system characteristics and capabilities across all conditions and populations, or to be focused on a subset of these (disease specific)?



### Medical Home - A way out of a familiar provider / payer stalemate



- o “Change and perform and then we will pay differently” and “Pay differently and that will drive our change”
- o This dilemma is often heard with important insights on both sides, but usually framed as an “either-or” which is unlikely to be settled.
- o DIAMOND is an example of nice balance in action of 2 perspectives.
- o What have we learned about how to balance the perspectives for collaborating on medical home?
  - Learning’s from DIAMOND
  - Getting stakeholders more acquainted and trusting of each other?
  - Potential “us – them” which requires a new approach
- o How do we get past this from here?





### What medical home is not... a gatekeeper model in disguise

- If primary care providers are seen again merely as gatekeepers, they will not be seen as (or feel like) advocates.
- Healthcare home aims to put patient health and experience first, but at same time asks providers to be stewards of resources on behalf of all of us. We can improve patient experience and health outcomes while improving resource stewardship.
- To distinguish from what is feared as a gatekeeper model to cut costs vs. a medical home that provides coordination and value (cost & quality):
  - How do we identify or develop tools to provide the patient with enough information where to receive the best care?
  - How do we make sure that productive conversations take place about whether, for example that a MRI or knee replacement is needed? Shared decision making



### Strategy Work – The journey...

Words of wisdom... "All of this will not be finished in the first 100 days. Nor will it be finished in the first 1,000 days, not in the life of this administration, nor even perhaps in our lifetime on this planet. But let us begin."  
John F. Kennedy in his inaugural address

**"Change starts when someone sees the next step."**  
William Drayton; American judge

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