

Transforming Healthcare in Minnesota through Patient-Centered Medical Homes

What is the patient-centered Medical Home?

It's a promising new approach to healthcare delivery that improves health outcomes, enhances access and reduces overall costs.

What defines a Medical Home?

Medical Homes are patient-centered. They are defined by an on-going relationship between the patient and his/her personal physician. They are structured in a manner that is all about the patient, where all decisions meet their needs and values. The physician and his/her practice team provide primary and preventative care and help the patient navigate the complexities of the healthcare system by coordinating services with other qualified professionals, in partnership with patients and family caregivers.

The Medical Home model is built on widely-accepted principles:

- Each patient has an ongoing relationship with a personal physician.
- Care is provided by a physician-directed medical practice and supported by the efforts of a practice team.
- Care focuses on the whole person.
- Care is coordinated and integrated with other parts of the healthcare system.
- Priority is placed on high quality and patient safety.
- Patient access to healthcare is improved.

How is this approach different from the existing system?

The current healthcare system in the US rewards fragmented, high-volume, overspecialized and inefficient care. In contrast, the patient-centered Medical Home model is based on the premise that the best health care has a strong primary care foundation and clear incentives for quality and efficiency.

How do we know if the Medical Home model works and meets the needs of patients?

The evidence supporting Medical Homes is extensive and compelling. The Robert Graham Center has documented more than 50 successful pilots and studies from around the world.* For example:

- Ten years of experience in Puget Sound demonstrated that Medical Homes can improve care quality and cost-effectiveness for patients with chronic disease – a huge cost driver in the current system.
- In North Carolina, 3,500 primary care physicians participated in 15 community-based Medical Home health networks. The \$10 million investment in 2006 saved the state \$244 million in overall healthcare costs.
- 1,100 Community Health Centers serving 16 million Americans saved billions of dollars a year by relying on a primary care system that employed a patient-centered Medical Home.
- Minnesota's Initiative for Special Needs children has shown statistically significant improvements in Medical Home Index scores.

*Source: "The Patient Centered Medical Home: History, Seven Core Features, Evidence and Transformational Change," AAFP, November 2007

What characterizes a Medical Home practice?

- It develops and supports longitudinal care relationships between patients and their personal physicians.
- It uses evidence-based guidelines to treat chronic conditions, acute illness and injury, and to provide preventive care.
- It coordinates care across all settings – practices, hospitals, nursing homes, consultants and other components of the healthcare network.
- It serves as the patient's "library" of health care information.
- It uses a team approach, capitalizing on the expertise of mid-level practitioners and medical subspecialists for greater efficiency.
- It uses health information technology (registries, electronic prescriptions, electronic health records, personal health records, secure e-mail) to facilitate patient care.

How do patients benefit from Medical Homes?

They benefit directly through greater/easier access to needed services, improved quality of care, more attention to prevention, and early identification and management of health problems.

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How are Medical Homes different from managed care?

Medical Homes serve as facilitators, not as gatekeepers. They ensure that patients receive the care they need, when they need it. One of their fundamental roles is coordinating care among subspecialists, providing access to them, and helping patients understand how subspecialist care impacts their overall healthcare.

How do practices become Medical Homes?

They will adopt care-enhancing measures and mechanisms demonstrated to achieve the core goals of the medical home model. Usually, it is only primary care practices (not individual doctors or other subspecialties) can be designated as patient-centered Medical Homes. The National Committee for Quality Assurance is developing and refining the designation criteria. The Medical Home designation will be *voluntary* and is not related to board certification.

Are there any active Medical Home pilots in Minnesota or the Midwest?

- 23 pediatric and family medicine Medical Home teams participate in the Minnesota Department of Health learning collaborative, which is the largest Medical Home learning collaborative in the country.
- Owatonna Medical Home incorporated nine elements of the Medical Home over a three-year period.
- The Veterans Administration has linked 155 hospitals, 135 nursing homes and 45 rehabilitation centers to an online universal medical records system – a move that supports coordinated care.
- Seven major health insurance companies have partnered with the Patient-Centered Family Practice Collaborative to conduct demonstration projects.
- GE, IBM, Boeing and Medicare are conducting multi-state projects.
- TransforMED is conducting a national demonstration project of 36 practices ready to “transform.”

How much support is behind the Medical Home model?

Medical Homes are considered a fundamental part of healthcare reform. Support is gaining strong momentum around the US and in Minnesota.

- The Council of State Governments passed a resolution in November 2007 urging its members to implement and fund Medical Home pilots. Fourteen states took immediate action.
- Seven of the nation’s largest health benefits organizations pledged their support in September 2007 to the national collaborative promoting the Medical Home model. They include Aetna, BC/BS, Cigna, Humana, MVP Health Care and United Healthcare.
- Minnesota’s Legislative Commission on Health Care Access has built its health care reform recommendations around the Medical Home model. The Governor’s Health Care Transformation Task Force is forming alliances with employers and private health care buyers to identify performance expectations, and working to form new public-private partnerships around strategies.
- Major health care organizations, and their Minnesota affiliates, are united in their support:
 - American Academy of Pediatrics
 - American College of Physicians
 - American Osteopathic Association
 - American Academy of Family Physicians
- Minnesota’s most influential health care organizations are publicly recognizing the value of the Medical Home concept to improve the quality of outcomes and cost-effective delivery of care.
 - Institute for Clinical Systems Improvement (ICSI)
 - National Institute of Health Policy (NIHP)
 - Minnesota Medical Association (MMA)
 - Minnesota Hospital Association (MHA)
 - Minnesota Academy of Family Physicians (MAFP)

What challenges lie ahead?

The next major challenge is not in winning support for medical home but in transforming practices to best meet the needs of individual patients, physicians, providers and communities. One part of that transformation involves concretely understanding what it means to be a Medical Home in practice, so that we can achieve all of its goals. Another part involves payment reform which recognizes that Medical Homes add value for patients and provide cost savings for the system as a whole. Finally, Medical Home practices will need to continue their participation in health care work-force education and add to the body of evidence-based medicine through practice-based and community research.