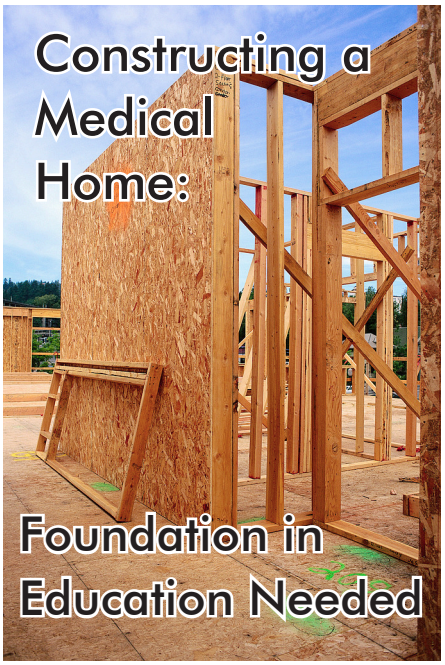

The concept of a "medical home" is not new. The American Academy of Pediatrics (AAP) paved the way by advocating a medical home for every child, especially those with special healthcare needs, starting in the 1960s. In the late 1990s, the term became part of the lexicon of both the American Academy of Family Physicians (AAFP) and the American College of Physicians. The latter group coined the phrase "advanced medical home" in a January 2006 policy statement.[1] Today, many emergency physicians refer to those requesting non-urgent care in emergency departments (EDs) as the "medically homeless."[2]

In its 2004 report, "The Future of Family Medicine: A Collaborative Project of the Family Medicine Community," the AAFP said that "steps must be taken to ensure every American has a personal medical home that serves as the focal point through which all individuals — regardless of age, sex, race, or socioeconomic status — receive a basket of acute, chronic, and preventive medical care services. Through their medical home, patients can be assured of care that is not only accessible but also accountable, comprehensive, integrated, patient-centered, safe, scientifically valid, and satisfying to both patients and their physicians."[3]

Survey Results Identify Knowledge Gap: Nearly Half of Respondents Unfamiliar with the "Medical Home"

From a policy standpoint, the healthcare industry appears to be pinning its hopes on medical homes to transform the quality and availability of care and dramatically reduce healthcare costs. However, the results of the Healthcare Intelligence Network (HIN) November 2006 online survey indicate that a great many opportunities still exist to educate various industry sectors about this practice. When HIN asked healthcare organizations if they were familiar with the idea of a medical home, almost half of 231 respondents — 46.3 percent — said they were not. Many reported that they had never heard the term "medical home," while others erroneously associated it with remote monitoring of patients, in-home care or a physical structure.

Of the 124 respondents whose organizations are familiar with the concept, more than half — 62 percent — are already trying to establish medical homes for their patient and client bases. Besides these organizations, slightly more than a dozen respondents plan to begin this process in the coming year.

When the organizations who said they had no plans in this area in the next 12 months were asked why, their responses were varied.

"We are evaluating the concept and working with several physician groups to explore opportunities for a medical home program," said one respondent.

"[The] hospital has not identified [this] as a priority," said another respondent, adding that "reimbursement for such service was unclear."

Several other respondents said they were waiting to see how reimbursement trends would develop before committing to the idea.

Some responses reflected confusion with the concept of medical homes, which do not represent a physical structure but rather a concept of care.

The Medical Home's Pediatric Roots

The field of pediatrics first defined the medical home in the 1960s. According to the AAP, a medical home consists of the following elements:

- ✓ A partnership between the family and the child's/youth's primary healthcare professional;
- ✓ Relationships based on mutual trust and respect;
- ✓ Connections to supports and services to meet the non-medical and medical needs of the child/youth and their family;
- ✓ Respect for a family's cultural and religious beliefs;
- ✓ After-hours and weekend access to medical consultation;
- ✓ Families who feel supported in caring for their child; and
- ✓ Primary healthcare professionals coordinating care with a team of other care providers.

One Organization's Take on the Medical Home

Different interpretations of the phrase "medical home" abound. In 1992, the AAP defined the concept for its population in this policy statement:

- ✓ The medical care of infants, children, adolescents and young adults ideally should be *accessible, continuous, comprehensive, family-centered, coordinated, compassionate* and *culturally effective*.
- ✓ It should be delivered or directed by well-trained physicians who provide primary care and help to manage and facilitate essentially all aspects of pediatric care.
- ✓ The physician should be known to the child and family, and be able to develop a partnership of mutual responsibility and trust.

The AAP states that a medical home can be a physician's office, a hospital outpatient clinic, a community health center or school-based clinic, as long as it provides the services that constitute comprehensive care. Those services include continuous access to medical care (24 hours a day, seven days a week); when appropriate, referral to pediatric medical subspecialists and surgical specialists; and interaction with child care, early childhood education programs and schools to ensure that the special needs of the child and family are addressed.

Source: AAP Policy Statement on Medical Homes, as published in July 2002 Pediatrics Journal.[4]

Disclaimer: HIN survey results are not based on a scientific sampling but on the number of responses to the HIN monthly online survey at www.hin.com.

Twelve states (California, Connecticut, Florida, Idaho, Iowa, Louisiana, Maryland, Mississippi, Rhode Island, Texas, Washington and West Virginia) have passed laws to create or encourage the creation of medical homes for children. Some state programs target children with special healthcare needs while others recommend a medical home for all children.

In the wake of Hurricane Katrina, the Louisiana Health Care Redesign Collaborative is proposing a revamping of the state's healthcare system that would be built upon a

> "We're very interested in [medical homes], but still in the information-gathering stage. It seems to make a lot more sense to do this than to continue to pay vendors for add-on services to achieve the same outcomes. Unfortunately, it does not look like health plans can deliver on this well."
>
> *A health plan contributes to the November 2006 HIN online survey, "The Medical Home."*

medical home model system of care.[5] The collaborative submitted its plan to the Centers for Medicare and Medicaid in October 2006.

Concerned about a region that is reeling from a post-Katrina reduction of primary care physicians, specialists and hospital beds, the collaborative hopes that a medical home model will "form the foundation for coverage of the uninsured, as well as for the ultimate transformation of the way care is provided in the current Medicaid program. Ideally, the medical home model will eventually be applied across all spectrums — including the private sector. This should result in better quality and lower costs and ultimately will improve access to health insurance."[6]

Targeted Populations

Of those respondents where medical home assignment is regular practice, slightly more than a third have attached 21 percent or more of their clients to medical homes. Just over a third — 36.4 percent — say they've assigned 5 percent or less of their population so far.

When assigning medical homes, most healthcare organizations (43 percent of respondents) are likely to target their Medicaid population. Next on the list are Medicare patients, who are being targeted by 32.1 percent of respondents engaged in medical home assignment. Commercial populations are getting the attention of 30.4 percent of respondents actively involved in the assignment of medical homes.

Tying a member of the commercial population to a medical home can sometimes pose a challenge. "The commercial population cannot be limited to a specific provider," contributed one respondent. "The patient is allowed to choose and can see whomever they would like."

Assigning a medical home requires acceptance and understanding on the part of the patient or member. One respondent has a unique way of encouraging patient compliance. "Members are asked to complete a personal health covenant, which is between the member and medical home," contributed a survey participant.

Increased Patient Satisfaction and Improved Outcomes Are By-Products of Medical Home Creation

Almost half — 49 percent — of respondents establishing medical homes for their populations have noted increased patient satisfaction. Moreover, 41.2 percent of these have observed improved patient outcomes.

Also, several hospitals and health plans said they have already noticed a reduction in ED visits. While it's too early to put a price tag on this development, a continued reduction in this area could result in substantial savings for providers and payors. The National Center for Health Statistics determined that of the 108 million ED visits nationally in 2000, 10.7 percent were for non-emergencies.[7] In a March 1996 article, the New England Journal of Medicine estimated that the average charge for an ED visit was $383.[8]

Early Adopters Share Strategies for Success

Among those organizations trying to establish medical homes for clients, almost half — 48.3 percent — rely on a case manager or health coach for assistance in making this connection. Slightly less than half — 44.8 percent — require a patient or member to identify a primary care provider upon enrollment or admission. Slightly more than a third — 41.4 percent — are educating their population about the importance of the medical home via marketing and communication efforts.

Respondents from various sectors of the healthcare industry shared strategies that are helping them establish medical homes for their patients and/or members:

From Hospitals	From Health Plans	From DM Companies
Relationship with community health partners to communicate to patients importance of having a medical home.	Outreach coordinators who live in the neighborhoods.	Using community outreach workers, particularly bilingual, bicultural individuals with appropriate cultural competency.
Referrals; Identifying frequent ED users (without a primary care provider) with chronic conditions such as diabetes and congestive heart failure.	Information systems with predictive modeling to identify eligible members.	Placing health coaches in health clinics.
Healthcare access information on Web site.	Care management.	Providing care and support for HIV/AIDS-affected patients and other diseases.
Automatic referral to Federally Qualified Health Centers or public health clinic upon entry to health system.	Marketing initiatives to make enrollees aware of medical homes and how they can improve their quality of life.	Using a comprehensive, patient-friendly health monitoring system.
Patient self-selects provider.		Establishing focus groups.

The Role of the Primary Care Provider

The creation of medical homes requires buy-in from family physicians, who often become the "medical home." Gaining this support requires education and training on the various principles of the medical home, which some medical schools are making part of their curriculum. In the University of Hawaii Integrated Pediatric Residency Program, pediatric residents must complete a practice module on the medical home model.[9] The module educates and tests them on medical home principles, then requires them to apply the principles during case study review and later during actual patient encounters. During these encounters, the residents must complete a "Resident Medical Home Performance Checklist" that includes two action items for each of the seven tenets of the medical home: family-centered care, accessibility, coordinated care, continuous care, compassion, comprehensive care and culturally effective care.

Related Resource

Industry experts believe that establishing medical homes for all can help reduce the number of "medically homeless" in hospital EDs and the number of unnecessary ED visits. As the industry slowly socializes the concept of medical homes, hospitals and health plans are trying other methods, including education, to redirect non-urgent care to settings other than the ED. For example, just teaching patients not to call their doctor at 4:30 on a Friday afternoon can reduce unnecessary ED utilization.

Teaching timely access to outpatient care is just one tactic covered in *For Emergency Use Only: Curbing Unnecessary Emergency Room Use Through Education, Accountability and Physician Engagement*, a special report based on an October 2006 HIN audio conference. This report provides a blueprint for health plans, hospitals and providers desiring to address and reduce unnecessary ED utilization in their populations. This report provides details on:

- ✓ Initiatives and interventions for decreasing non-urgent ED use;
- ✓ Mining data to target high-utilization, high-cost individuals and communicating proper ED use to targeted populations;
- ✓ Implementing an ED case management program; and
- ✓ Enlisting physicians' support in care redirection and appropriate ED use.

For more information, please visit http://store.hin.com/product.asp?itemid=3566

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